STATE TITLE V BLOCK GRANT NARRATIVE
STATE: OK
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Assurances Non-Construction Programs, Form 424B, is signed by the Oklahoma Commissioner of Health. The Certifications regarding debarment and suspension, drug-free workplace requirements, lobbying, Program Fraud Civil Remedies Act (PFCR), and environmental tobacco smoke are also signed by the Oklahoma Commissioner of Health. The original signed documents are kept in a central folder in the Maternal and Child Health Service (MCH) at the Oklahoma State Department of Health. Copies are available upon request by contacting MCH Administration at (405)271-4480 or paulaw@health.ok.gov.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Oklahoma provides access for the public to the annual report and application throughout the year via an active link to the federal Maternal and Child Health Bureau (MCHB), Title V Information System (TVIS) website. This active link is found on the Maternal and Child Health Service (MCH) web page on the Oklahoma State Department of Health's (OSDH) website. Hard copies of the annual report and application are provided on request. Input via e-mail, letters and telephone calls have been received throughout the year from those who have reviewed the document. Comments have focused on support for the current services provided and requests for information about activities of MCH and the Children with Special Health Care Needs (CSHCN) Program.

Public input was received from state and community partners and families during work group meetings June - October 2004 focused on gathering information for inclusion in the Title V needs assessment. These work groups were specific to the areas of women and infants, children and adolescents, and CSHCN.

Public input was sought through a statewide press release, March 10, 2005. The press release was also sent to radio stations and minority newspapers located throughout the state to gain input from various racial, ethnic and cultural groups (American Indian, Asian, African American, Latino and Chinese). In addition, the Family Voices in Oklahoma newsletter contained an article requesting public input in its March/April 2005 issue.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Oklahoma is a largely rural state with two major metropolitan areas, one located centrally in the state (Oklahoma City) and the other 104 miles to the east (Tulsa). In each of the quadrants and the panhandle of the state, smaller cities provide some of the benefits of the two large metropolitan areas on a lesser scale. Scattered throughout the remainder of the state are rural towns of varying size and population. Population in rural areas is decreasing while the two large metropolitan areas have experienced the most growth over the past five years. Farming continues to shrink and small businesses struggle to survive in a climate of corporate and urban growth. Gaming (lotteries and casinos) is becoming a major contributor to the state's economy with revenue reaching nearly 1 billion this year and expected to increase.

Overall, Oklahoma is primarily Caucasian with other non-white and/or Hispanic populations being less than 22% of the state's population. Larger populations of other non-white and/or Hispanic populations are found in eastern and southeastern Oklahoma. There are 39 federally recognized Native American tribal governments with Native American populations integrated into local communities. Oklahoma has no reservations though federally it is considered a reservation state. In recent years, a steady growth in the Hispanic population is occurring, at first in rural farming communities with movement now into growing urban communities. Pockets of predominantly African American/Black communities are found in central and eastern Oklahoma.

For 2004, the total size of the maternal and child health age-targeted population including children ages 0 through 19 and females ages 20 through 44 stood at 1,572,444 or 44.6% of the total population (3,523,600) for 2004. The population of children and adolescents under the age of 18 dropped 3.6% from 2000-2004.

Oklahoma is a poor state even though the state's economy is currently performing well with general revenue fund collections and additional funds being received from gross production tax on oil and natural gas. The 2003 per capita personal income for the state was $26,719 (85% of the national value) with only eleven other states reporting lower per capita incomes. Unemployment stood at 4.5% in April 2005. However, even with relatively low unemployment, the state suffers from high rates of uninsured persons. Many jobs are low wage and temporary positions (e.g., call centers, live stock processing, lawn/garden services).

As indicated earlier, the gaming industry is growing and becoming a significant contributor to the state's economy. In November 2004, Oklahoma voters approved state questions that are expected to create millions more in state revenues. State Question 705 created a state lottery and State Question 712 provided for the creation of the State Tribal Gaming Act. Oklahoma's lottery is slated to begin October 1, 2005 with scratch-off lottery tickets, electronic lottery games are to begin April 2006 and Powerball games tied to lotteries in other states are to begin October 2006. Proceeds from the lottery are earmarked to support state education. The State Tribal Gaming Act authorizes a limited number of electronic games at three of the four horserace tracks in the state (Remington Park, Blue Ribbon Downs and Will Rogers Park) and provides a model compact which Indian tribes in the state may enter into to conduct such gaming on Indian lands. Related to approval of these new games under the State Tribal Gaming Act, tribal casinos are expected to continue to expand in Oklahoma. Oklahoma Indian tribes currently operate more than 80 casinos throughout the state.

Oklahoma's political climate is shifting. Marked changes, attributed largely to constitutional term limits, occurred in the Oklahoma Legislature with elections in November 2004. Thirty-nine new legislators were elected to the House and fifteen new members to the Senate. For the second time in state history, Republicans gained control of the House (57 to 44) and are optimistic that they will gain control of the Senate (currently Republicans hold 22 of the 48 seats) in November 2006 when nine Democratic Senators cannot seek re-election due to term limits. Democrats are a minority in the House for the first time since 1921-22 when Republicans dominated the House for one term. The House elected a Republican speaker 84 years to the day that the only other Republican was elected

to the post. The House also elected the state's first female speaker pro tempore, also a Republican. These Republican House leaders work with a Democratic controlled Senate and a Democratic Governor.

During this year's legislative session, several key bills were passed and signed by the Governor targeting positive outcomes for Oklahoma's maternal and child health populations. These include legislation to promote good health and nutrition in the school setting, Senate Bill (SB) 265 requires healthy choices in school vending machines and SB 312 requires physical education in grades K-5 with physical education to be offered as an elective in middle and high school. With a focus on reducing child and youth automobile related morbidity and mortality, SB 799 increases the fine for violation of the Child Passenger Restraint Law from $25 to $50 plus all court costs and House Bill (HB) 1653 provides for graduated driver's licenses for drivers younger than 18. It is expected with the graduated driver's licenses that accidents and fatalities among drivers younger than 18 will be reduced by at least 15%. SB 435 and HB 1547 both lower state taxes. SB 435 lowers taxes by raising the standard deduction on state income taxes. HB 1547 includes a reduction in the income tax rate from 6.65% to 6.25%. In efforts to provide ongoing support for Oklahoma's youngest populations, HB 1094 ensures current levels of child care funding in the Oklahoma Department of Human Services (OKDHS) by increasing the state's share as federal funds decrease, HB 1080 provides funding to the State Department of Education for full-day kindergarten and HB 1020 provides an additional $1 million in funding for SoonerStart, Oklahoma's early intervention program for 0 to 3 year olds. To assist with liability concerns and curb the loss of health care providers in rural areas of the state providing services through the Oklahoma State Department of Health (OSDH) system, SB 983 amends the Maternal and Infant Care Improvement Act to provide coverage under the Government Tort Claims Act for licensed health care providers contracting with the OSDH.

Additional good news is the multiple opportunities presenting to increase access to health care services for the maternal and child health populations. Through HB 1088, an additional $63 million in state funds has been appropriated to the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, to gain a federal match to place nearly $200 million total into the Oklahoma Medicaid system to increase provider and hospital reimbursement rates. Over the next year, it is anticipated that the OKDHS and the OHCA will finalize and implement plans to move from a six-month eligibility period to a 12-month eligibility period to facilitate continuity of care for Medicaid recipients.

On January 1, 2005, an expansion of the state Medicaid program began allowing breast and cervical cancer treatment for Oklahoma women less than 65 years of age. This expansion is made possible due to Governor Brad Henry signing the Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund Act in May 2004 enabling the state to exercise the federal option under the State Medicaid Plan to provide breast and cervical cancer services for an expanded eligibility group of Oklahoma women. Women who meet eligibility criteria and have received an abnormal screen for either breast or cervical cancer are eligible for the full scope of Medicaid services through SoonerCare, the state's Medicaid program. Each woman will choose a primary care provider and receive needed specialty referrals through the primary care provider. In addition, she will have available care management services, transportation through SoonerRide, the SoonerCare Helpline and Nurse Advice Line. Eligible women will continue to receive services through SoonerCare until they are determined to no longer be in need of cancer treatment.

On April 1, 2005 the Oklahoma Family Planning Waiver was implemented. This 1115(a) research and demonstration waiver allows for family planning services to be provided to individuals who would otherwise not be eligible for Medicaid. Eligible individuals are uninsured women and men ages 19 and older with family income at or below 185% of the federal poverty level (FPL). This category includes women who gain eligibility for Title XIX (Medicaid) reproductive health services due to a pregnancy but whose eligibility ends 60 days postpartum. Medical benefits are limited to reproductive services currently covered under the state Medicaid plan.

Disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits

because of their parent's income or resources may be eligible for services under Section 143 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248). This option allows children who are eligible for institutional services to be cared for in their homes. Only the child's income and resources are used in determining financial eligibility. The cost of care at home compared to the cost in an institutional setting is also used in determining eligibility. Children who meet eligibility requirements may be eligible for the full range of Medicaid covered services. The program implementation date is set for October 1, 2005 with income from the new tobacco tax that took effect on January 1, 2005 to provide state funds for this expansion.

Funds generated from the new tobacco tax are also to be used to support implementation of the Premium Assistance Program. Pending Centers for Medicare and Medicaid Services (CMS) approval, October 1, 2005 is the target date the OHCA has identified for initiating the first phase of the Premium Assistance Program that is being implemented under a Health Insurance Flexibility and Accountability (HIFA) Waiver. This first phase of the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) allows persons who work for employers with less than 25 employees to become Medicaid eligible if household income is less than 185% FPL. The client will have to pay a portion of the insurance premium and the employer has to pay a portion of the insurance premium. The state plans to devote an average of $50 million per year to the initiative.

Given the many positive changes occurring with health care services for the maternal and child health populations, Oklahoma still faces significant challenges. These include the need to improve its system of emergency/trauma care; the continuing influx of the undocumented Hispanic population and a system of care not fully prepared to deal with absorbing the additional costs of serving this population, as well as differences in culture and language; loss of physicians providing obstetric care due to high malpractice premiums; closure of obstetric units in rural hospitals due to loss of physicians and inability to meet standards of care for the provision of emergency obstetric care; and, inadequate reimbursement for health care services.

Oklahoma is working to improve its emergency medical system with the expected outcome of a fully implemented trauma system to save one in five lives currently lost. Trauma is the leading cause of death for Oklahomans ages 1 to 44 and costs Oklahomans more years of productive life than all diseases combined. Oklahoma is being divided into eight regions to pinpoint ambulance services and levels of emergency care available at each hospital within the region. Oklahoma trauma victims, classified as Priority 1, Priority 2 or Priority 3 depending on the type and severity of their injuries, will be triaged to the most appropriate hospital emergency room for treatment. The University of Oklahoma is currently the state's only Level 1 trauma center managing all types of trauma. Tulsa's St. John's and St. Francis hospitals have the state's only Level 2 trauma units. All other hospital emergency rooms are classified as either Level 3 or Level 4. On July 1, 2005, Oklahoma City and Tulsa began operating trauma triage and transfer call centers to help direct trauma victims and personnel to the most appropriate hospital emergency room. It is anticipated that this regionalization will also assist with and provide a model for addressing concerns currently faced by the state in relation to emergency obstetric and newborn care.

Discussion is currently underway between the OHCA, the OKDHS and the OSDH regarding Medicaid expansion of health coverage for uninsured and underinsured pregnant women under the State Children's Health Insurance Program (SCHIP). This expansion would allow Medicaid to cover services for these pregnant women for the benefit of the health of the unborn child. Currently these women are receiving their health care primarily through the statewide county health department system which includes contracted services through community clinics in Oklahoma and Tulsa counties; the University of Oklahoma and Oklahoma State University's teaching environments (clinical and hospital); and, the state's federally qualified community health centers (FQHCs).

The public health system in Oklahoma includes the OSDH, county health departments in 67 of 77 counties with 87 service sites in these organized counties, and contract community providers. The City-County health departments in Oklahoma and Tulsa counties have their own personnel systems and are administratively separate from the state system. The remaining county health departments

are administrative units of the OSDH. The CSHCN Program provides services in all 77 counties in the state. In addition, two medical schools are located in Oklahoma with one in Tulsa and the other in Oklahoma City, which also maintains a Tulsa campus. In addition, the College of Public Health within the University of Oklahoma Health Sciences Center (OUHSC) campus in Oklahoma City contributes significantly to the advancement of public health in Oklahoma through its education and training programs.

There are currently eight FQHCs in Oklahoma operating 17 access sites: Central Oklahoma Family Medical Center (Konawa); Family Health Center of Southern Oklahoma (Tishomingo); Kiamichi Family Medical Center (Battiest); Mary Mahoney Memorial Health Center (Langston, 2 Oklahoma City sites); Morton Comprehensive Health Services (Nowata, 3 Tulsa sites); Oklahoma Community Health Service, Inc. (Oklahoma City, Ft. Cobb, Tipton); Northeastern Oklahoma Community Health Centers (Hulbert, Tahlequah, Muskogee); and, Stigler Health and Wellness Center (Stigler). During the 2005 legislative session, over $2 million was appropriated to support existing FQHCs and expand Oklahoma FQHCs. Just over a million of these funds is to be used for the reimbursement of care provided to uninsured clients. Another million is to be used for enhancing and developing FQHCs in Oklahoma (e.g. contract for grant writing services, provide transitional operational assistance for new FQHC organizations). Oklahoma also received $2.85 million this year for four new community health centers (Clayton, Fairfax, Idabel and Tulsa) from the Health Resources and Services Administration, Bureau of Primary Health Care.

Native Americans are increasing their visibility related to the investments they are making in improving Oklahoma's health. Newspaper stories and paid television spots depict the services and changes occurring. Access to health care for tribal members in the rural areas of the state is through tribe specific health facilities. Intertribal urban clinic facilities are found in Tulsa and Oklahoma City and hospitals operated by Indian Health Services are in Claremore, Tahlequah and Lawton.

Given changing culture, economics, political climate and health care systems in Oklahoma, creative and flexible prevention and intervention approaches are required to adequately address the health needs of the maternal and child health populations. Maternal and child health leaders and other state health leaders are continuously challenged to enhance existing pieces and design new pieces to assure a comprehensive quality system of health care. Ongoing collaborative partnerships are key to their success.

B. AGENCY CAPACITY

Under the provisions of Public Law 97-35, Section 509(b), the OSDH and the OKDHS share the administration of the Oklahoma Title V Program. Administration of services to women, infants, children and adolescents is provided by the OSDH through the Maternal and Child Health Service (MCH). Administration of services to children with special health care needs is administered by the OKDHS. Since the Omnibus Budget Reconciliation Act (OBRA) of 1981, the OKDHS has received its designated portion of the Title V monies to operate the Children with Special Health Care Needs (CSHCN) Program. The statutory authority which designates the OKDHS to operate the CSHCN Program is covered in Title 10 of the Oklahoma Statutes 1981, Section 175.1 et. seq. and article XXV of the Oklahoma Constitution.

The OSDH and the OKDHS collaborate to administer the CSHCN Program through a memorandum of agreement between the two agencies. This memorandum of agreement outlines the relationship between the two agencies to include responsibilities for the Title V Block Grant annual report and application. Copies may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

MCH and the CSHCN Program meet monthly to plan and coordinate activities. During these meetings, staff share updates on services and collaborate on strategies to improve services. In addition, these meetings provide the opportunity to coordinate activities in preparing the Title V Block Grant. MCH coordinates pulling all MCH and CSHCN information together for submission of the

needs assessment, annual report and application with the CSHCN Program providing MCH with its written responses to be incorporated into each of these areas of the grant. These meetings also provide a forum to engage other programs such as Newborn Metabolic Screening, Genetics, Early Intervention (SoonerStart), Dental and the Women, Infants and Children supplemental nutrition program (WIC) in discussions and collaborative planning.

MCH partners with all Services in the Family Health Services (FHS): Child Guidance; Screening, Special Services and SoonerStart; Family Support and Prevention; Dental; and, WIC. MCH funds directly support services provided by Dental (statewide dental needs assessment of third grade children in public school, community-based dental clinics and dental health education) and Screening, Special Services and SoonerStart (newborn metabolic and hearing screening, and birth defects registry).

MCH possesses a strong relationship with the OSDH Community Health Services (CHS). The CHS receives MCH funds for direct, enabling, population-based and infrastructure services delivered through the statewide county health department system. The county health department system consists of 67 county health departments with 87 service sites. Monthly meetings occur between MCH and CHS to coordinate budget and health care service issues that arise.

MCH works closely with all areas within the OSDH. The OSDH Commissioner of Health facilitates a monthly Executive Team Meeting that all Deputy Commissioners, Service Chiefs and Program Directors attend. This meeting provides the opportunity for agency updates, sharing of activities from programs, asking of questions and informal networking. MCH also participates on key agency committees and work groups that focus on data systems, analysis, and utilization; retention of personnel; personnel budgeting; cultural respect; agency forms; and, compliance with the Health Insurance Portability and Accountability Act (HIPAA). The Deputy Commissioner of the FHS has two meetings a month with Chiefs of all Services administratively organized under the larger FHS. These meetings provide the opportunity for the Chief of MCH to interact with all Chiefs in FHS and to discuss collaborative activities. MCH works closely with FHS Services on health issues such as dental care of mothers and children, nutrition, childhood obesity, injury prevention, newborn hearing screening, newborn metabolic screening, genetics, prevention of birth defects, teen pregnancy prevention, school health, family resource and support services, child care and early childhood.

In addition to ongoing collaborative activities and meetings throughout the year, MCH facilitates annual meetings each year with the CHS, Dental, Public Health Laboratory and Screening, Special Services and Soonerstart to discuss activities to be accomplished in the next state fiscal year and budgeting of Title V MCH funds within these Services' budgets to support planned activities. These meetings occur in the spring of each year to better coordinate establishment of annual state fiscal year budgets (July 1- June 30).

Services for MCH populations are also accomplished through professional service agreements (e.g. physician, nurse practitioner), vendor contracts (e.g. ultrasounds, supplies), contracts with other state governmental agencies and invitations to bid (ITBs). Oklahoma City County Health Department and Tulsa City County Health Department, who are administratively separate from the OSDH, are key providers of MCH services in the two large metropolitan areas through direct contracts. Other community-based providers provide MCH services through professional service agreements or the ITB process.

The CSHCN Program oversees the provision of services to children receiving State Supplemental Income (SSI) by providing training and guidance to the 45 social services specialists located in OKDHS county offices across the state. These social services specialists are responsible for writing and monitoring services plans for all SSI children who receive benefits through the OKDHS. All equipment and services available through Title V CSHCN must be pre-approved by the state office.

The CSHCN Program initiates and monitors professional service contracts with clinics that provide care to neonates in the Tulsa and Oklahoma City metropolitan areas. The CSHCN Program also

contracts with physicians for provision of psychiatric services to children in the OKDHS custody. In addition to contracting with a respite care facility, the state's referral and resource network for CSHCN and a program that provides integrated community-based services for CSHCN, the CSHCN Program also meets with these contractors at least quarterly to ensure CSHCN goals are being met through these contracts. The CSHCN Program also has a representative on numerous parent advocate groups for CSHCN throughout the state and attends their meetings at least every other month.

C. ORGANIZATIONAL STRUCTURE

In Oklahoma, state health and human services are loosely organized under the Cabinet Secretary for Health and the Cabinet Secretary for Human Services who are appointed by the Governor. Terry Cline, Commissioner of the Department of Mental Health and Substance Abuse Services (DMHSAS), is the Cabinet Secretary for Health and Howard Hendrick, Director of the OKDHS, is the Cabinet Secretary for Human Services. Health and human services agencies in Oklahoma include the OSDH, OKDHS, DMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, OHCA and Oklahoma Commission on Children and Youth. The Department of Corrections and the Oklahoma Department of Education are under different cabinet secretaries. The Oklahoma Commission on Children and Youth is charged with planning and coordinating children's services in the state in addition to providing oversight for juvenile services. The agency heads of all the major agencies serving children are appointed to serve on the Oklahoma Commission on Children and Youth.

Oklahoma administers the Title V Program through two state agencies, the OSDH and the OKDHS. The OSDH is authorized to receive and disburse the Title V MCH Block Grant Funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108 as the state health agency. These sections create the OSDH, charge the Commissioner of Health to serve under the Board of Health and outline the Commissioner of Health's duties as "general supervision of the health of citizens of the state." Title 10 of the Oklahoma Statutes, Section 175.1 et.seq. grants the authority to administer the CSHCN Program to the OKDHS.

The Title V MCH Program is located in the OSDH within the FHS. The FHS is organizationally placed under the Commissioner of Health. Suzanna Dooley, M.S., A.R.N.P., Chief of MCH is directly responsible to the Deputy Commissioner of the FHS, Edd Rhoades, M.D., M.P.H., who is responsible directly to the Commissioner of Health, James M. Crutcher, M.D., M.P.H. Organizational charts of the OSDH, FHS and MCH are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

The Title V CSHCN Program is located in the OKDHS within Health Related and Medical Services (HRMS). HRMS is organizationally placed under the Family Support Services Division. Karen Hylton, B.A. is the Director of the CSHCN Program and Program Manager for HRMS. Karen Hylton is directly responsible to Jim Struby, B.A. Programs Administrator. Jim Struby is directly responsible to Mary Stalnaker, M.S.W, Family Support Services Division Director. Mary Stalnaker is directly responsible to Farilyn Ballard, M.S.W., Chief Operating Officer Human Service Centers who is responsible directly to the Director of OKDHS, Howard Hendrick, J.D. Organizational charts of the OKDHS, Family Support Services Division, HRMS and the CSHCN Program are on file in MCH with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

D. OTHER MCH CAPACITY

MCH consists of MCH Administration and three Divisions: Child and Adolescent Health, Women's Health and MCH Assessment. MCH Administration consists of Service level administrative support staff as well as the Public Health Social Work Coordinator, MCH Nutritionist and MCH Family Advocate who work across all MCH programs. The Child and Adolescent Health Division staff are primarily nurses and health educators. Programs and services include child health clinical services, school health, adolescent health, early childhood, child care, suicide prevention, teen pregnancy prevention and injury prevention. The Women's Health Division staff are nurses, nurse practitioners and health educators. Programs and services include maternity, family planning and preventive health

education services for females and males of reproductive age. MCH Assessment staff are epidemiologists, biostatisticians and program analysts. These staff evaluate MCH programs and services. MCH Assessment staff are also responsible for carrying out statewide population-based surveillance to include the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Middle School Risk Behavior Survey, the Fifth Grade Health Survey and the First Grade Health Survey.

Suzanna Dooley, M.S., A.R.N.P., is the Title V MCH Director and Chief of MCH. Beth Ramos, M.P.H., is the Director of the Child and Adolescent Health Division. Cedar Jackson, M.S., A.R.N.P., is the Director of the Women's Health Division. Dick Lorenz, M.S.P.H., is the Director of MCH Assessment. Jim Marks, M.S.W., Public Health Social Work Coordinator, Nancy Bacon, M.S., MCH Nutrition Consultant, Lyn Thoreson, MCH Family Advocate, and Paul Patrick, M.P.H., MCH Data Contact, are also part of MCH leadership. The Child and Adolescent Health Division is currently in the process of identifying a new medical director as the previous medical director resigned June 30, 2005 to pursue other interests. Pamela Miles, M.D., from the Department of Obstetrics and Gynecology, University of Oklahoma Health Sciences Center, Oklahoma City campus, serves as the Medical Director to the Women's Health Division through a contractual agreement. Brief biographies of the leadership for MCH are attached.

The MCH central office organizational chart currently shows 40 full time equivalent (FTE) positions of which 38 are currently funded for 2006. Of these, 27.05 positions are funded on Title V Block Grant funds with the remaining 10.95 positions funded on state and other federal grant funds.

The Chief of MCH has a routine planning meeting on Tuesday morning of each week with MCH Directors, the Public Health Social Work Coordinator, the MCH Nutritionist, the MCH Family Advocate and other MCH staff as identified depending on the area(s) being addressed. These meetings have assisted MCH to accomplish activities related to setting of priorities and initiating plans of action. These meetings have also provided a routine time for MCH to meet with other areas in the agency such as HIV/STD, Public Health Laboratory, Office of Primary Care and Turning Point as specific issues have needed to be addressed. On every other Monday morning, MCH has a routine staff meeting for all staff involved in MCH Comprehensive Site Visits. These meetings allow for development and revision of site visit policy, procedure and tools as well as coordination of site visit schedules. MCH also has a general staff meeting every other month that brings all MCH staff together for agency updates, training and Service-wide planning.

Karen Hylton, B.A., Program Manager for HRMS, is the Title V CSHCN Director. Other state office staff includes Frank Gault, M.S.W., Programs Field Representative, Family Support Services Division and Mike Chapman, B.A., Supplemental Security Income-Disabled Children Program (SSI-DCP). Robert Brown, M.D., is the Medical Director for the OKDHS and also the CSHCN Program. Brief biographies of the CSHCN Program leadership are attached.

The system used by the OKDHS to track the number of FTE in the CSHCN Program is different than that used by the OSDH. No FTE within the OKDHS is totally funded by Title V. Approximately 48 FTE were involved with the CSHCN Program during the last fiscal year.

The CSHCN Program has parent involvement to include support for parent positions in various CSHCN programs (Oklahoma Areawide Services Information System (OASIS) parent coordinator - 1, OASIS staff - 5, Oklahoma Infant Transition Project -- 1 and Tulsa Neonate Follow-up Clinic - 1).

State office CSHCN staff meet at least weekly to discuss training needs, plan site visits and discuss CSHCN issues. Mike Chapman meets with field staff (either individually or collectively) at least monthly to provide training and discuss activities surrounding provision of services to SSI children.

The CSHCN Program meets monthly with the State Interagency Coordination Council, which was set up by SoonerSUCCESS, a CSHCN contractor. This Council consists of representatives from parent organizations, the Medical Home Program and other state agencies.

E. STATE AGENCY COORDINATION

The OSDH and the OKDHS coordinate closely with other state health and human services agencies. The Commissioner of Health and the Director of the OKDHS coordinate state planning and activities for shared priorities on a regular basis with Directors of other state agencies. Meetings occur more frequently at particular times of the year, such as when the legislature is in session, than at other times of the year.

The OSDH and the OKDHS enjoy a particularly close and supportive relationship with the OHCA, the state Medicaid agency. These relationships have been instrumental in facilitating the development and implementation of services to benefit the MCH populations, to include CSHCN (e.g. breast and cervical cancer treatment, family planning waiver, TEFRA). Staff from the three agencies work together daily using each other's expertise as resources. Communication is continuous with input openly sought from each of the agencies as they accomplish their responsibilities.

Another close relationship is with the University of Oklahoma, particularly the OUHSC campus. The OSDH, as the state's public health agency, actively participates in activities of the OUHSC and vice versa. The OSDH provides opportunities for students to complete clinical rotations, internships and preceptorships. Joint educational activities such as classroom instruction, grand rounds, conferences and clinical training are accomplished in collaboration with the Department of Obstetrics and Gynecology, Department of Pediatrics, College of Public Health, School of Nursing, Child Study Center and College of Dentistry. The Department of Pediatrics and University of Oklahoma (OU) Physicians are key partners in supporting the SAFE KIDS Oklahoma, a state level coalition focused on prevention of childhood injuries. The College of Public Health works with the OSDH to facilitate accomplishment of Public Health Certificates and/or Master and Doctorate of Public Health Degrees for OSDH staff both at the state and local levels.

In addition to OU, the OSDH and the OKDHS link with colleges and universities across the state to provide students seeking health and human services related degrees with hands-on learning experience. For each experience, a formal written agreement with goals and objectives for the experience and evaluation of the student's progress are outlined between the faculty, agency staff and student. Students complete assignments by working side-by-side with county and/or state office staff.

The Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND) Program at the OUHSC Child Study Center receives support from both state agencies. The OSDH and the OKDHS along with other health and human services state agencies participate in planning meetings and provision of practicum experiences. The MCH Family Advocate is an Oklahoma LEND Family Mentor and assures students gain exposure to the issues faced by families in accessing and maintaining needed services for a child with special needs.

Early childhood is a priority area of the state for which both agencies are providing leadership through collaborative partnerships. Through support of the Oklahoma Partnership for School Readiness (OPSR), a legislatively established public-private partnership, Oklahoma is finalizing a state plan for early childhood to be implemented in state fiscal year 2006. Partnerships with the State Department of Education, Head Start, local 4-year old programs and child care providers are facilitating establishment of full day kindergarten, early Head Start programs and improved requirements and guidelines for licensed child care facilities.

Joint activities are accomplished with state medical and nursing associations. These include initiatives to impact the health status of Oklahomans; planning for and evaluation of health services; publishing of data and corresponding recommendations for health systems improvement; and, training and education presentations.

The Oklahoma Hospital Association provides critical linkage and credibility to activities needing to be accomplished with hospitals across the state. This relationship has assisted with implementation of important services such as statewide newborn hearing screening, evaluation and restructuring of the emergency medical system, and state preparedness in the event of a natural or planned disaster.

The OSDH and the OKDHS work closely with FQHCs and tribal health care facilities to assure access to health care services. County health departments and local OKDHS offices work with these providers to link clients with needed services not available through the OSDH and the OKDHS. These partners are central to assuring access to primary care services, particularly for the uninsured and underinsured populations. Support of the Oklahoma Primary Care Association and the OSDH Office of Primary Care's efforts to expand FQHCs in Oklahoma is a priority.

The OSDH and the OKDHS are two of 11 state agencies and programs participating in the Joint Oklahoma Information Network (JOIN), a data-sharing project with goals of helping state agencies provide services more efficiently and helping Oklahomans find community resources and programs and determine their eligibility for them. It is available at www.join.ok.gov. Other participating organizations include the OHCA, Oklahoma Commission on Children and Youth, Office of Juvenile Affairs, State Department of Education, Oklahoma Employment Security Commission, Oklahoma State Finance Office, Oklahoma Commerce Department, Oklahoma Rehabilitation Department and DMHSAS. JOIN is being developed in phases. The first phase, a statewide information and referral system/resource database, is active. The second phase, a de-identified aggregate database for research, service planning and quality assessment is currently being compiled. The third phase, individual client information for single point of entry and case management, is in the planning stage.

F. HEALTH SYSTEMS CAPACITY INDICATORS

See Forms 17, 18 and 19.

Data are received from multiple sources for these indicators: the OSDH Center for Health Care Information, the OHCA, the PRAMS, the OKDHS and national data sets. Examples of data used are vital statistics, Medicaid enrollee data, Medicaid claims data, SCHIP enrollee data, SCHIP claims data and census data.

The OSDH continues to develop its Public Health Oklahoma Client Information System (PHOCIS). This system provides clinical information on maternity, child health and family planning clients and services. Modules continue to be refined for enabling, population-based and infrastructure services. This system has a link with the Oklahoma State Immunization Information System (OSIIS), the immunization statewide registry, and WIC, the supplemental nutrition program for women, infants and children.

In looking at Oklahoma's status related to the Health Systems Capacity Measures, one must take into consideration the time period of the data available, difference in data collection systems and changes that have occurred in health care systems such as improved data collection and, until more current data is available, the unknown impact the change in Medicaid from a Health Maintenance Organization (HMO) to a preferred provider organization (PPO) model in 2005 will have on these measures.

HEALTH SYSTEMS CAPACITY MEASURE #01
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.
In 2003, the latest year for which hospital discharge data are available, there were 996 hospitalizations for asthma among children under five years of age. The rate of asthma hospitalizations for this age group was 42.4 per 10,000 children. The asthma hospitalization rate shows a dramatic increase between the years 2001 and 2002, from 25.1 to 42.7. This sudden rise is an artifact due to improvement in the number of facilities reporting data. In 2001, only 69 (53%) facilities reported data to Health Care Information (HCI), the responsible data authority at OSDH,

whereas in 2002, 122 (94%) facilities submitted data to HCI.

HEALTH SYSTEMS CAPACITY` MEASURE #02
The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screening.
Data for year 2002 are the latest that are currently available to MCH. In that year, approximately 75% of Medicaid enrollees less than one year of age received at least one initial or periodic screening under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Recent data from the state Medicaid agency show that the percent of infants receiving an initial or periodic screening has declined from 79.3% in year 2000.

HEALTH SYSTEMS CAPACITY MEASURE #03
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.
Data for year 2003 are the latest that are currently available to the MCH program. In 2003, approximately 83% of SCHIP enrollees less than one year of age received at least one initial or periodic screening under the EPSDT program. Recent data from the Oklahoma Health Care Authority show that the percent of infants receiving an initial or periodic screening has declined from 85.9% in year 2001.

HEALTH SYSTEMS CAPACITY MEASURE #04
The percent of women (15 through 44) with a live birth during the reporting period whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index.
For 2003, approximately 3 in 4 mothers (77.8%) received 80% or better of the expected prenatal care visits as measured by the Kotelchuck prenatal care adequacy index. Generally, despite a minimal decline since 1999 (79.7%), the performance for this measure has been comparatively flat over recent years.

HEALTH SYSTEMS CAPACITY MEASURE #05
Comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the state.
a) Percent of low birth weight (< 2,500 grams).
Monitoring data for this measure are extracted from PRAMS population-based surveillance. In 2003, the most recent year for which data are available, 7.9% of mothers participating in the Medicaid program delivered infants at low birth weight. This compares to 6.0% for mothers not receiving Medicaid benefits. That is, births to Medicaid mothers were 1.3 times more likely to be low birth weight than non-Medicaid births. For Oklahoma overall, 6.9% of all births were low birth weight. Compared to 2002 reported low birth weight data, the Medicaid population experienced a decrease (down from 8.6%), the non-Medicaid population showed an increase (up from 5.7%), and overall the State experienced a decrease (down from 7.2%).

b) Infant deaths per 1,000 live births.
Infant death data by Medicaid participation are unavailable. The infant mortality rate for Oklahoma was 7.7 infant deaths for every 1,000 live births in 2003. This is a decrease (down 5%) from last year's reporting when the IMR was reported at 8.1 for 2002.

c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
Tracking data for this health indicator come from the PRAMS surveillance project and represent the latest available, calendar year 2003. Mothers receiving Medicaid benefits enter prenatal care during the first trimester less frequently (67.2%) than do non-Medicaid mothers (82.8%). Oklahoma PRAMS data show that overall nearly three in four pregnant women (74.6%) initiate prenatal care in the first trimester. Since last year's reporting that reflected PRAMS 2002 data, Medicaid mothers have increased (up from 60.4%) and non-Medicaid mothers have decreased (down from 84.3%) in the proportion seeking timely prenatal care. Overall, PRAMS data indicate a 2-percentage point climb (up from 72.3%) in the rate of early entry into prenatal care for Oklahoma mothers.

d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]).
The Oklahoma PRAMS surveillance project provides data for tracking this health indicator. In 2003, the most recent year for which data are obtainable, disparity was evident for this measure when compared by Medicaid participation. Mothers who were Medicaid recipients were less likely to achieve adequate prenatal care (65.3%) than non-Medicaid mothers (73.6%). Overall, about 69% of pregnant women receive adequate prenatal care as measured by the Kotelchuck Index. This measure does show a change for both the Medicaid and non-Medicaid populations from PRAMS 2002. The proportion receiving adequate levels of prenatal care has increased for Medicaid mothers (up from 62.6%) and decreased for non-Medicaid mothers (down from 77.8%). Overall, no appreciable change has been observed in this measure from year 2002 (69.9%).

HEALTH SYSTEMS CAPACITY MEASURE #06A
The percent of poverty level for eligibility in the State's Medicaid programs for infant (0 to 1), children, Medicaid and pregnant women.
The income eligibility levels for Medicaid enrollment qualification remain unchanged from the previous reporting. For 2004, the income threshold continued to be 185% of federal poverty level for infants, children and pregnant women.

HEALTH SYSTEMS CAPACITY MEASURE #06B
The percent of poverty level for eligibility in the State's SCHIP programs for infant (0 to 1), children, SCHIP and pregnant women.
The income eligibility levels for SCHIP enrollment qualification remain unchanged from the previous reporting. For 2004, the income threshold continued to be 185% of federal poverty level for infants, children and pregnant women.

HEALTH SYSTEMS CAPACITY MEASURE #07
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Forty percent of eligible children in this age group received dental services via the EPSDT program in 2004. This marks a substantial increase in the proportion of eligible children that have received EPSDT dental services. In 2001, only 18% of EPSDT eligible children among this age group received dental services.

HEALTH SYSTEMS CAPACITY MEASURE #08
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.
Data for the current reporting period are not yet available. In 2003, 73% of SSI beneficiaries under the age of 16 received rehabilitation from services provided through the CSHCN Program. Long-term data are incomplete and fail to provide an adequate basis for comparative discussion. The proportion of SSI beneficiaries receiving rehabilitative services in 2003 did increase over the previous year's reporting (66% in 2002).

HEALTH SYSTEMS CAPACITY MEASURE #09A
(GENERAL MCH DATA CAPACITY)
The ability of the State to assure MCH Program access to policy and program relevant information.
Access to databases not under the direct authority of the MCH program area remains largely unchanged. An exception is the annual data linkage of birth and infant death records. MCH, via work performed under the State Systems Development Initiative (SSDI), has access to linked birth/infant death files. This is new for calendar year 2005. Plans are to maintain this linkage as routine for the MCH programs. Despite some progress on data availability, electronic linkages to other external data for Medicaid or WIC continue to be unfulfilled. MCH has limited access to registry data from hospital discharge and birth defects by means of agency partnerships established over time. PRAMS data are collected and maintained within MCH Assessment, providing direct access to survey data and linkages to birth records.

HEALTH SYSTEMS CAPACITY MEASURE #09B
(DATA CAPACITY -- ADOLESCENT TOBACCO USE)
The percent of adolescents in grades 9 through 12 who reported using tobacco products in the past month.
The Oklahoma Youth Risk Behavior Survey (YRBS) is conducted within the MCH program area. As a result, MCH analysts have direct access to data collected by YRBS surveillance activities. This is unchanged over previous years' reporting.

HEALTH SYSTEMS CAPACITY MEASURE #09C
(DATA CAPACITY -- OVERWEIGHT/OBESITY)
The ability of the State to determine the percent of children who are overweight or obese.
Organizationally, the Youth Risk Behavior Survey (YRBS) is located within the MCH program area. Analysts and program personnel have direct access to data and study findings to use in addressing issues related to overweight or obesity among adolescents. The Pediatric Nutrition Surveillance System (PedNSS) is not a surveillance vehicle in which Oklahoma participates. Data are not available to MCH from this project. Program data from WIC are available to MCH as part of the Public Health Oklahoma Client Information System (PHOCIS), the State's direct services database. MCH has access to these data through the OSDH computer network system, in which MCH analysts link to PHOCIS data, including WIC, by way of Microsoft Access tables. This briefly described availability of program and analysis data from YRBS, PedNSS and WIC has not changed since the federal fiscal year (FFY) 2005 MCH Block Grant submission.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Government Performance and Results Act (GPRA), enacted in 1993, requires federal agencies to establish standards measuring their performance and effectiveness. Performance measures are used to monitor the effect that Title V services have on important health outcomes and processes. These measures in effect are markers of progress in improving health and reducing related risks of our target populations. While many external forces beyond the control of the Title V programs can affect these measures, they still provide direction for Title V services and assure that the focus remains on health improvement. Figure 3, Title V Block Grant Performance Measurement System, presents a schematic approach that begins with the needs assessment and identification of priorities and culminates in performance measures leading to improved outcomes for the Title V population.

Every five years, a comprehensive needs assessment is accomplished with state priorities identified. Based on these priorities, state performance measures are developed and resources allocated to impact the priorities. During interim years, needs assessment activities continue to monitor changes and identify gaps that may impact priorities and performance measures. In addition, MCH and the CSHCN Program evaluate the resources assigned to address each priority. Based on the continuing needs assessment process and the annual evaluation of resources and their impact, state priorities may be redefined, performance measures changed and resources realigned resulting in changes in specific program activities within the four levels of the MCH "pyramid" (direct health care, enabling, population-based and infrastructure building services).

MCH uses the national and state performance measures in the agency performance and budget report submitted each fall to the state legislature by the Oklahoma State Department of Health (OSDH). These measures are part of the OSDH strategic plan for improving the health of Oklahomans.

The national outcome measures and national and state performance measures are also shared by MCH and the CSHCN Program with internal and external partners so they are aware of Title V priorities and the focus of resources. This assists with planning of collaborative activities and more effective use of limited resources in addressing common priorities.

B. STATE PRIORITIES

The selection of Oklahoma priorities began with a new needs assessment process that assured input from a broad group of individuals from across the state rather than just Title V staff. Three teams were organized to assist the Title V Program in identifying needs from the perspectives of service providers, consumers, advocates and other state and community-based agencies. The three teams represented the three MCH population groups: women and infants, children and adolescents and children with special health care needs. Individuals were identified to represent the broad scope of Title V services and activities and invited to participate in a planning meeting followed by subsequent separate meetings to identify needs for their respective populations. MCH and CSHCN program staff strictly limited their participation to being group facilitators to avoid unnecessary influence from an internal perception of issues and problems.

The initial planning meeting was held for all participants to provide them with a background of Title V, an explanation of the legislation mandating performance-based planning and expectations of each group to provide useful feedback for setting state priorities. The three groups worked independently June through October 2004 and were given wide latitude in determining their recommendations. They were offered access to any available data to support their identification of needs. Upon completion of their work, a list of priorities was submitted by each group that identified the highest needs of their respective population groups of women and infants, children and adolescents and children with special health care needs.

MCH and CSHCN leadership reviewed these recommended priorities to assess and compare them to the mission of Title V and the scope of the MCH and CSHCN programs. A preliminary set of priorities was then selected that best fit the highest priorities of each of the three groups; consideration was given to overlap, mandated services and historical priorities.

An analysis of data was accomplished to determine what needs could be quantified. Data were analyzed from the following sources: population-based surveillance data from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Centers for Disease Control and Prevention (CDC) weighted Oklahoma Youth Risk Behavior Survey (YRBS), the Oklahoma First Grade Health Survey, and the Oklahoma Fifth Grade Health Survey; Oklahoma vital records; 2000 U.S. Census and Census population estimates; the State and Local Area Integrated Telephone Survey (SLAITS); needs assessments of other Oklahoma MCH programs; private, non-profit health-based surveys or studies; agency program data from the OSDH and the Oklahoma Health Care Authority (Medicaid data); and, other federal and state surveys. These data were reviewed and analyzed to assess need and to compare with the qualitative assessments provided initially by the three groups.

A final examination of the initial priorities was then made by MCH and the CSHCN Program to assure that the identified issues remained consistent with their own experiences as well as the priorities of the respective agencies. The priorities were modified slightly, based upon a careful review of the resources available and the relationship of Title V to other services that will partner with the MCH and CSHCN efforts (note that no one priority is ranked higher than another):

1) Reduce the prevalence of obesity among the MCH populations
2) Reduce substance abuse behaviors in the MCH populations
3) Improve access to dental health services by pregnant women and children
4) Increase access to prenatal care
5) Improve the system of respite care for CSHCN families
6) Improve transition services for adolescents with special health care needs
7) Reduce unwanted, unplanned pregnancies
8) Increase the proportion of fully immunized children entering school
9) Increase the proportion of mothers who breastfeed their infants
10) Improve data access and file linkages of public health databases

Next, MCH and the CSHCN Program analyzed existing national performance measures and current state performance measures to determine their usefulness in addressing the new priorities. It was noted that national performance measures addressed several of the state priorities. State performance measures no longer pertinent to the priorities were discontinued, and new measures were created to assist the state in monitoring its progress toward impacting the priorities. Four previous state performance measures were retained with three new state performance measures* developed for 2006:

1) The percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.
2) The percent of mothers who smoke during the third trimester of pregnancy.
3) The percent of adolescents grades 9-12 smoking tobacco products.
4) The number of families with a child with special health care needs receiving respite care provided through the CSHCN Program.
5)* The percent of first grade students at risk for overweight (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution).
6)* The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.
7)* Percent of children with special health care needs that receive timely and appropriate transition services.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			100	100	100
Annual Indicator			100.0	100.0	100.0
Numerator			38	36	31
Denominator			38	36	31
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Data were obtained from Screening and Special Services, Oklahoma State Department of Health. All newborns born in Oklahoma are screened for congenital hypothyroidism, galactosemia, phenylketonuria and sickle cell disease.

Notes - 2003

PM#1: Data were provided by Screening and Special Services, OSDH.

Notes - 2004

Data were obtained from Screening and Special Services, Oklahoma State Department of Health. All newborns born in Oklahoma are screened for congenital hypothyroidism, galactosemia, phenylketonuria and sickle cell disease.

a. Last Year's Accomplishments

All newborns born in Oklahoma were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease and other hemoglobinopathies. The number of disorders identified in calendar year (CY) 2004 included: PKU (4); congenital hypothyroidism (13); classic galactosemia (1); sickle cell disease (13); hemoglobin disease (0); hemoglobin C trait (133); and, sickle cell trait (405). Follow-up testing was received by 100% of newborns with an abnormal screen (traits not included), up from a historical 96% - 98%. NSP staff assured that all infants with positive results were linked with providers for needed follow-up services. For CY 2004, 100% of the sickle cell traits and hemoglobin C traits were referred for counseling provided through the Sickle Cell Association.

Year three of the four-year Oklahoma state genetics implementation grant began May 31, 2004. This grant, "Genetic Services-Improving the Health of Children: Implementation of the State Grants for the Integration of Programs and their Information Systems," funded a full-time state genetics coordinator; a state genetics education coordinator; an education program that

provides ongoing education inservices to hospitals and providers; a quality assurance program from heelstick to long-term outcome; a long-term follow-up program that provides case management for infants identified with a metabolic disorder; and, a Healthy and Ready to Work Program (HRTW) which will provide adult transition services, career planning and other services for adolescents with sickle cell disease.

Based on earlier negotiations completed in April 2003 with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, the Oklahoma State Department of Health (OSDH) Public Health Laboratory began to bill Medicaid for newborn dried blood spot screenings. In February 2004, the OSDH Board of Health broadened the public health newborn screening program and changed the billing methodology from a kit cost to billing by CPT code for each laboratory test. In July 2004, Medicaid receipts and other OSDH funds began to be used to fund NSP expansion activities.

The State Genetics Program continued to staff and provide support for the Oklahoma Genetics Advisory Council (OGAC). The OGAC held three meetings during the year with subcommittees of the council also meeting routinely (18 committee and 10 newborn screening expansion workgroup meetings were held in 2004). Close collaboration continued to occur between the program, OGAC and other key stakeholders to assess and develop the genetics and newborn screening program infrastructure. In February 2004, the OSDH Board of Health approved expansion of newborn screening for medium-chain acyl coenzyme-A dehydrogenase deficiency (MCAD), cystic fibrosis (CF) and congenital adrenal hyperplasia (CAH). Planning began for implementation of the expansion scheduled to occur during 2005-06.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide newborn metabolic screening for 100% of the newborns born in Oklahoma.			X	
2. Provide short-term follow-up to assure health care linkage for all infants with abnormal lab.		X		
3. Provide long-term follow-up of affected infants to include care coordination and support services in collaboration with the medical home.		X		
4. Provide genetic education programs to hospital staff and medical providers.				X
5. Provide administrative support for the Oklahoma Genetics Advisory Council (OGAC).				X
6. Plan for expansion of newborn metabolic screening to include medium-chain acyl coenzyme-A dehydrogenase deficiency (MCAD), cystic fibrosis (CF) and congenital adrenal hyperplasia (CAH).				X
7.				
8.				
9.				
10.				

b. Current Activities

The change in billing methodology from a kit cost to billing by CPT code for each laboratory test was implemented in April 2005.

Key newborn screening infrastructure components of the state genetics plan for long-term follow-up and adult transition services have been established. One hundred percent (100%) of infants identified with a disorder through newborn screening are being referred for care coordination services.

Statewide genetics education efforts continue with provision of educational seminars at every level, from high school to health care provider, and media campaigns for family history promotion and expansion of the newborn screening program (18 genetic lectures, Genetics Day at the Capitol information reception, five public forums and a brochure developed to assess breast cancer risk, a self assessment guide). The brochure was distributed at the "Race for the Cure," and order forms were mailed to providers throughout the state to promote broad distribution. The newborn screening pamphlet has been updated for expansion and includes what other states offer for newborn screening as recommended by Peter Van Dyke, M.D. (letter received in 2004). The pamphlet has been designed to better meet the information needs of families as directed by information attained at the National Newborn Screening Meeting in Atlanta, May 2004.

On February 14, 2005, the NSP expanded to screen all newborns for CF and CAH.

The CSHCN Program and NSP collaborate through scheduled meetings to include participation at least quarterly in routinely scheduled MCH and CSHCN meetings.

c. Plan for the Coming Year

All newborns born in Oklahoma will be screened through the NSP within Screening, Special Services and SoonerStart Service for the disorders of PKU, congenital hypothyroidism, galactosemia, CF, CAH, sickle cell disease and other hemoglobinopathies. Starting fall 2005 or early 2006, the program will expand testing to include MCAD. After expansion for MCAD, the program in collaboration with OGAC will review uniform screening panel recommendations from the American College of Medical Genetics (ACMG). It is anticipated that of the 54 disorders recommended by the ACMG, Oklahoma will screen for 53 disorders with screening to be fully implemented in 2006. Currently, Oklahoma screens for 11 of the disorders and current expansion plans for MCAD will enable the program to screen for 41 of the metabolic disorders recommended by the ACMG. Additional equipment will need to be purchased to screen for Biotinidase deficiency.

The NSP will maintain comprehensive short-term follow-up services to assure all infants with abnormal lab results are followed until resolution (e.g. diagnosed as normal, affected or lost to follow-up). Affected newborns are followed until documentation of treatment date, if applicable, referral to pediatric subspecialist and enrollment into available long-term follow-up services.

The NSP will continue to provide long-term follow-up services to include care coordination and support services for all affected newborns except for CF. All follow-up services are in collaboration with the medical home. The NSP will continue to provide education and low phenylalanine formula to women with PKU wishing to have a child and have expanded the program to provide this service to all adults with PKU. The program has funded a metabolic dietitian with recruitment being accomplished to fill the position. The NSP will continue to work closely with the long-term follow-up programs to ensure the needs of individuals and families are met.

The OGAC will continue to meet at least three times during the year. A metabolic workgroup will continue to meet to facilitate the implementation of expansion for the genetic disorder of MCAD and the other metabolic disorders that the lab methodology can detect. The Newborn Screening Programs and Pediatrics Committee of the OGAC will continue to meet annually to identify and discuss important newborn screening issues. These meetings will be scheduled for

the fall of 2005 and during 2006.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				52	53.8
Annual Indicator			50.4	50.4	50.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54.9	56	57.4	58.8	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

PM#2: Measure were pre-populated by data from the SLAITS CSHCN survey.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Data for this national performance measure are derived from the National Survey of Children with Special Health Care Needs included in the State and Local Area Integrated Telephone Survey (SLAITS), conducted under the auspices of the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC). Fifty percent (SLAITS, 2001) of children 18 years or younger have families that contribute to health-related decision making and report satisfaction with received services. This marks the first instance of SLAITS publication of data related to CSHCN. Consequently, trend data are unavailable.

As a result of the community forums that were held in 2003 the overall visibility of the CSHCN Program increased. There were more parents who had direct contact with CSHCN Program staff. The CSHCN Program continued to work with vendors to increase the role of the parents in the plan of care for their children.

The Pediatric Sickle Cell Clinic started a monthly parent support group that allows parents to discuss problems and solutions for children with sickle cell disease. The Oklahoma Areawide

Services Information System (OASIS) joined with a consortium to expand service available on the 1-800 line and on the web. For a portion of the year, the CSHCN Program funded a position for a parent to act as a family liaison at the University of Oklahoma Health Sciences Center (OUHSC). This person participated in team meetings at the OUHSC clinics to give input from the perspective of families with children who have special health care needs. The Oklahoma Infant Transition Program (OITP) had a parent coordinator on their team who helped families deal with the issues confronting newborns with special health care needs.

The CSHCN Program was awarded a Maternal and Child Health Bureau (MCHB) Grant through the Champions for Progress Center at Utah State University. The purpose of this grant was to develop a survey and gather information from parents and medical professionals on how they prefer to receive and give information regarding CSHCN issues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to vendors to increase the role of parents in the plan of care for their child.				X
2. Fund parent advocate positions as part of contractual agreements with providers.				X
3. Provide support for monthly parent support group for parents of children with sickle cell disease.		X		
4. Develop survey to gather information from parents and medical professionals on how they prefer to receive and give information regarding CSHCN issues.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN Program was able to post the survey developed through the Champions for Progress Grant on the CSHCN web page on the Oklahoma Department of Human Services (OKDHS) website to assist in gathering data for the project. The results of the survey showed that parents want to have input in decision-making for their children but need support to help them understand the process and know how to become involved. Over half of the respondents thought that "telling providers what families need and want, their experiences with raising a child with special health care needs and what they worry about" would be beneficial to programs from the design stage through service delivery to program evaluation. Respondents indicated they prefer serving on committees and answering surveys as their primary way of contributing to the planning and evaluation process for the CSHCN Program. Families need to believe that provider systems will listen to their ideas before they expend the time and effort to participate. The overall consensus from providers who responded to the survey was that they used family input to "decide what services to offer", "decide what kind of staff to hire", "develop materials for families about our services" and "decide where to offer services." The CSHCN Program plans to use the information from the survey to implement alternative methods of getting parents involved. The survey remains on the OKDHS/CSHCN web page with changes

to refine the survey to be accomplished in the coming year.

The CSHCN Program continues to contract with SoonerSUCCESS at the Child Study Center, OUHSC. SoonerSUCCESS has established a model for a multi-tiered, unified comprehensive service system that builds community capacity and integrates existing public and private service programs in six counties in Oklahoma. This project has begun building a community-based infrastructure by coordinating the efforts of health, mental health, social and educational systems, identifying existing public and private services, identifying service gaps and developing community-based strategies to fill those gaps. The CSHCN Program is paying for detailed resource directories to be provided in three of the counties in the SoonerSUCCESS Project. One of the directories was published and is being distributed while the other two are in the process of being printed.

The State Coordinator for SoonerSUCCESS applied for a MCHB State Implementation Grant for Integrated Community Systems for Children with Special Health Care Needs through the Child Study Center. The Child Study Center has been awarded the grant. The grant will be used to expand the SoonerSUCCESS model to the rest of the state by organizing all 77 counties into clusters of six to ten counties around a larger community where basic services may be congregated. The target population in each region will be CSHCN children and their families.

c. Plan for the Coming Year

Work will be done to further refine the survey developed through the grant with the Champions for Progress Center and it will remain posted on the OKDHS/CSHCN web page. The data gathered from this survey will be used to help the CSHCN program develop alternative methods of getting input from parents and caretakers regarding their satisfaction with services they receive.

To accomplish the requirements of the MCHB State Implementation Grant that was awarded to the Child Study Center, the CSHCN Program will work closely with the staff of the SoonerSUCCESS Project as they expand to new regions in the state and develop best practices for enlisting families to partner in decision-making.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				54	56.7
Annual Indicator			53.3	53.3	53.3
Numerator					
Denominator					
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.8	59.3	60.5	62	63.5

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

PM#03: The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The National Survey of Children with Special Health Care Needs (SLAITS, 2001) indicate that approximately 53% of special needs children less than 19 years of age have a medical home that meets the criteria specified under National Performance Measure #3. Trend data are not available, as this survey has not been repeated to date.

MCH and the CSHCN Program met with the President of the Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) to discuss support and strategies for expanding medical home in Oklahoma. It was agreed that an ongoing visible collaborative partnership was critical to enhance the success of activities supporting medical home.

The Tulsa Neonate Program and the Sickle Cell Clinics continued to provide services using the medical home model. Other CSHCN contractors voiced their support for the medical home practice model and strived to connect the individuals and families that they serve with a medical home practice as they transition away from the direct services provided by the program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the Oklahoma Chapter, American Academy of Pediatrics on strategies for expanding medical home in Oklahoma.				**X**
2. Support CSHCN contractors in their efforts to provide services using the medical home model.				**X**
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A new project is being implemented at the Oklahoma University Health Science Center (OUHSC), the largest teaching hospital complex in the state, to implement a medical home model in one of the clinics at the Children's Hospital. It is anticipated that the model will impact the health care practices of interns passing through the clinic and facilitate their use of the medical home model in their future practice of medicine. The coordinator of this project is located at the OUHSC Child Study Center and is supervised by the Coordinator of the SoonerSUCCESS Project.

The Medical Home Coordinator has developed a survey targeted at gaining input from pediatricians across the state on medical home. The survey is being printed and will be distributed by the CSHCN Program. The survey includes questions regarding services within the medical home model that come from a survey previously accomplished by the American Academy of Pediatrics. Input from this survey will assist the CSHCN Program and Child Study Center in developing services targeted to physicians to promote the use of medical home in providing care to children with special health care needs.

c. Plan for the Coming Year

MCH and the CSHCN Program will continue to collaborate with the OKAAP on activities to promote use of the medical home model. The commitment will continue to assure this is a visible collaborative partnership.

The CSHCN Program will continue to assist contractors to assure that families are supported in establishing a medical home and will continue providing information and technical assistance in order to increase the number of families that receive service through a medical home model.

The CSHCN Program will continue working with the Medical Home Coordinator at the Child Study Center to assist with any needs identified in assuring the medical home model is successful in the clinic at the Children's Hospital, as well as spreading the concept to primary care practices throughout the state. The CSHCN Program will facilitate discussions with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to offer incentives to medical providers who use the medical home model.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				58	59.5
Annual Indicator			56.4	56.4	56.4
Numerator					
Denominator					

Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61	62.5	64.1	65.4	67

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

PM#4: The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Data from The National Survey of Children with Special Health Care Needs (SLAITS) reveal that 56.4% of children 18 years or younger with special health care needs have sufficient levels of insurance coverage to provide for the necessary health services. Longitudinal data that track this measure over time are not yet available from SLAITS. The SLAITS 2001 survey was the first administration of the CSHCN questionnaire.

Medicaid continued to be the major funding source for medical services for the CSHCN population. The CSHCN Program continued to route referrals from the Social Security Administration on children who were approved for Supplemental Security Income (SSI) to the local county offices so contact could be made with the families to inform them of the availability of Medicaid and the CSHCN Supplemental Security Income - Disabled Children's Program (SSI-DCP). The CSHCN Program's contractors continued to assist individuals and families to establish eligibility for Medicaid.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link families referred from the Social Security Administration with Medicaid and Supplemental Security Income-Disabled Children's Program (SSI-DCP).		**X**		
2. Assist individuals and families to establish eligibility for Medicaid.		**X**		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Funding for the "Health Employee and Economy Improvement Act Revolving Fund", referred to as the "Premium Assistance Program", will be accomplished through revenue that will be generated due to Oklahoma voters approving a tax on tobacco products in 2004. Revenue from this tax will benefit several state programs including Medicaid. The beginning stages of implementation of this program will only benefit adults; however, future Medicaid program implementation is expected to include children who are not currently eligible for Medicaid.

The CSHCN Program is actively involved with the completion of a Tax Equity and Fiscal Responsibility Act (TEFRA) amendment to the state Medicaid plan. This will provide Medicaid coverage for individuals under age 19 who meet the Supplemental Security Income (SSI) definition of disability, have resources under $2000, income under 300% of the federal benefit rate (FBR), and meet an institutional level of care (either intermediate care facility (ICF), intermediate care facility for persons with mental retardation (ICF-MR) or hospital), but who are not currently eligible for Medicaid due to deeming of parent's income and resources. The appropriate level of care must be provided in the home and the cost of care in the home cannot exceed the cost of care in the institution. This will be the first major expansion of Medicaid for children with special health care needs in Oklahoma in many years. This expansion was also made possible due to voter approval of the tobacco tax.

c. Plan for the Coming Year

Language requiring contractors to help families establish eligibility for Medicaid will remain in all CSHCN contracts.

The CSHCN Program will facilitate discussions with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to expand the scope of Medicaid coverage under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program so that medically necessary services not currently being covered by Medicaid can be provided with Medicaid dollars. The CSHCN Program will also work with the OHCA to lengthen eligibility time frames so Medicaid eligible children will receive continuous benefits for at least 12 months rather than having to review eligibility every six months, which is the current practice for some Medicaid-eligible children with special health care needs who do not receive SSI.

To facilitate accomplishment of activities outlined in the Maternal and Child Health Bureau (MCHB) State Implementation for Integrated Community Systems for Children with Special Health Care Needs Grant awarded to the Child Study Center for expansion of community-based infrastructure for coordinating the efforts of health, mental health, social and educational systems, the CSHCN Program will assist SoonerSUCCESS, a state level multi-agency collaborative project, to identify gaps in public and private funding for needed services and develop a strategic plan for filling these gaps.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective				68	69.7
Annual Indicator			67.6	67.6	67.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	71.4	73.2	75.1	76.9	78.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

PM#5: The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

More than two-thirds (67.6%) of families with special needs children 18 years or younger report that community-based systems are structured to provide local services for which they can readily avail themselves. This information is provided from The National Survey of Children with Special Health Care Needs (SLAITS). Trend data are unavailable at this time.

The CSHCN Program was able to move beyond having to rely on anecdotal information from a few families about their perception of the services to a broad range of the population with the survey developed under the Champions for Progress Grant. The CSHCN forums held during the year increased the input from families and other interested stakeholders. This information combined with the results of the national CSHCN survey and the statistical information available through the Oklahoma Department of Human Services (OKDHS) provided a clearer picture of the service delivery system to the CSHCN population in Oklahoma.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use information gained from survey, community forums, SLAITS and OKDHS in assessing CSHCN service delivery system.				**X**
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Results of the survey developed under the Champions for Progress Grant showed that "easier access to services" emerged as the primary reason families wanted to be a part of planning services and programs. The top three locations families receive services were schools, doctor's offices and the OKDHS. Families responding to how they usually get information about services reported a broad range of methods. While some thought it was "dumb luck", others listed "support groups" or service providers; but most often it was personal research. Only about one-fourth of the respondents are satisfied with the effectiveness of service delivery.

The challenge found is a need to effectively coordinate services from all providers so that families will not have to repeat the same information over and over to different providers. To address this challenge, a "Cooperative Intake" form was designed by a SoonerSUCCESS regional workgroup with participants including families and agencies that serve children (SoonerSUCCESS is a state level multi-agency collaborative project supported with CSHCN funding and located at the Child Study Center, University of Oklahoma Health Sciences Center, with a primary focus on improving infrastructure of community-based service systems for children with special health care needs and their families). The goal is to get agencies and providers to adopt this form as a common intake tool. The CSHCN Program is sharing the information received from the survey with contractors and interested stakeholders.

c. Plan for the Coming Year

In an effort to address the issue of satisfaction with community-based service systems, the CSHCN Program plans to place more focus on the providers of services to the CSHCN population in order to gain more understanding of the available resources and provider insight and input on program development in the rural areas of the state.

The CSHCN Program will work closely with the Child Study Center to accomplish the requirements of the Maternal and Child Health Bureau (MCHB) State Implementation for Integrated Community Systems for Children with Special Health Care Needs Grant. Specifically, the CSHCN Program will work closely with SoonerSUCCESS to provide ongoing coordination of existing initiatives to work on improvement of access to and availability of screening, evaluation and referral mechanisms so parents/caretakers will not have to repeat the same information to multiple providers.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance				7.8	8.2

Objective					
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.2	8.4	8.6	8.7	8.8

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

PM#6: The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Approximately six percent (5.8%) of youth with special health care needs receive the essential services to transition to adulthood. This information was collected in The National Survey of Children with Special Health Care Needs (SLAITS), 2001. The CSHCN Survey is a relatively recent addition to the SLAITS panel of questionnaires. As a result, long-term data are unavailable.

The CSHCN Program worked closely with the Oklahoma Department of Rehabilitation Services (DRS), the state agency charged with assisting individuals with various disabilities to make the transition from school to work. An automatic referral process was established between the DRS and the CSHCN Supplemental Security Income -- Disabled Children's Program (SSI-DCP). The DRS worked with individuals and their families to establish an employment plan to lead to self-support.

The CSHCN Program worked with the Healthy and Ready to Work Program through the University of Oklahoma Health Sciences Center to assist the sickle cell population transitioning from pediatric providers to adult providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide automatic referral from the CSHCN Supplemental Security Income-Disabled Children's Program (SSI-DCP) to the Department of Rehabilitation Services (DRS) - facilitate establishment of employment plan.		**X**		
2. Provide technical assistance to the Healthy and Ready to Work Program to assist the sickle cell population transitioning from pediatric to				**X**

adult health care providers.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

b. Current Activities

The CSHCN Program is in the process of developing a questionnaire to be sent to individuals and their families who have aged out of the CSHCN SSI-DCP. It is hoped that the results will allow the CSHCN Program to determine how to improve services while the individual is in the program as well as when the time comes to transition to adulthood. The CSHCN Program is also developing an updated list of transition services available to the CSHCN population in the state.

Because of the lack of resources available to provide transition services and address transition issues, the CSHCN Program is developing a tool to gather information from individuals age 16 to 21 and their families. The CSHCN SSI-DCP services end at 18 years of age and the CSHCN Program hopes to be able to follow these individuals until their 21st birthday. In addition, the expectation is to gather information from disabled and blind individuals who receive a state supplemental payment through the Oklahoma Department of Human Services (OKDHS) as well as local school districts across the state. Once the information is compiled, the CSHCN Program plans to provide funding to entities that will focus efforts on providing specific transition services to the CSHCN population.

c. Plan for the Coming Year

The CSHCN Program plans to use information received from older youth with special health care needs, ages 16 to 21, disabled and blind individuals and local school districts to prioritize for funding specific transition services for the CSHCN population.

The CSHCN Program will also assist SoonerSUCCESS, a state level multi-agency collaborative project supported with CSHCN funding and located at the Child Study Center, University of Oklahoma Health Sciences Center, with the Maternal and Child Health Bureau (MCHB) State Implementation Grant for Integrated Community Systems for Children with Special Health Care Needs by helping to identify gaps in transition services, determine precipitating causes of the gaps and develop a strategic plan for filling those gaps.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance	**2000**	**2001**	**2002**	**2003**	**2004**

Data					
Annual Performance Objective	80	75	77	79	82
Annual Indicator	72.0	77.0	65.3	70.5	70.5
Numerator	34215	36591	31031	33502	33502
Denominator	47521	47521	47521	47521	47521
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83.6	85.3	87	88.8	90.5

Notes - 2002

Data for PM#7 were obtained from the National Immunization Survey, National Center for Health Statistics.

Notes - 2003

PM#7: Data were obtained from the National Immunization Survey, Centers for Disease Control and Prevention.

Population data were obtained from the U.S. Bureau of the Census.

Notes - 2004

PM#7: Data were obtained from the National Immunization Survey, Centers for Disease Control and Prevention. 2004 data are not available; therefore, year 2003 is repeated.

Population data were obtained from the U.S. Bureau of the Census.

a. Last Year's Accomplishments

National Immunization Survey (NIS) results for year 2003, the latest data available, showed a coverage rate of 70.5% for children less than two years of age who had received measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza and hepatitis B. This represents an increase from the previous year, in which the coverage rate was estimated by NIS at 65.3%. Prior years have witnessed the Oklahoma vaccination coverage rate for this age group oscillate from year-to-year.

The Oklahoma State Department of Health (OSDH) maintained its policy of providing immunizations to any child that presented at a county health department needing immunizations with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations were provided to an insured child, county staff worked with the parent/guardian to link the child with his/her primary health care provider for future immunizations. With the required move of Medicaid from the health maintenance organization (HMO) option to fee for service January 1, 2004, children were able to go to any county health department to receive immunizations and the OSDH receive reimbursement from Medicaid.

A contractual agreement remained in place with the Oklahoma Health Care Authority (OHCA) allowing reimbursement for Medicaid administrative costs related to the Oklahoma State Immunization Information System (OSIIS), Oklahoma's statewide immunization information registry.

MCH collaborated with the OSDH Immunization Service on The OK by One Project implemented in April 2004. This project, modeled after a similar project in New Mexico, was implemented as a strategy to improve vaccine protection levels. The OK By One Project offered a simplified immunization schedule, acceptable by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), that allowed completion of the primary vaccination series by the one-year-old well child visit.

Additional strategies to improve immunization rates included Immunization staff conducting immunization audits in 333 child care centers and providing over 200 clinics in both the public and private sectors with the CDC's Assessment, Feedback, Incentive and eXchange (AFIX) intervention. In addition, as part of MCH site visits to county health departments and contractors, immunization status of infants and children was reviewed with feedback provided to staff on strategies to improve rates.

MCH continued to participate in the OSDH Immunization Advisory Committee that met quarterly to update health care providers on current immunization issues and to seek input on ways to improve the system of care.

The OSDH maintained business partnerships during the year with Cox Communications, a telecommunications company, and the McDonald's Corporation. Public service announcements (PSAs) and other educational activities promoted a variety of immunization issues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintaining policy of providing immunizations to any child presenting at a county health department for immunization(s).				X
2. Provide outreach to the uninsured and underinsured populations.		X		
3. Assist families with insurance coverage to link with the child's primary care provider for immunizations.		X		
4. Maintain collaborative working relationship with the Oklahoma Health Care Authority, the state Medicaid agency, to assure provision of services and sharing of data for improvement of services.				X
5. Support statewide efforts of "The OK by One Project" to facilitate improvement in vaccine protection levels.				X
6. Monitor immunization services provided through site visits to service providers to assure children receive immunizations on schedule and to provide technical assistance to service providers on strategies to improve services.				X
7. Participate on the state Immunization Advisory Committee.				X
8. Maintain business partnerships facilitating public awareness and education of the importance of childhood immunizations.				X
9.				
10.				

b. Current Activities

Oklahoma currently ranks 48th of 50 states in the CDC's 2002 ranking of states related to children being up-to-date on immunizations by the age of 24 months. Oklahoma continues to place a strong emphasis on targeting pockets in need of immunization services and to use

population-based immunization surveys conducted in 63 counties to work with key health officials for each county to enhance rates. Additionally, cumulative state results and recommendations have been presented to the leadership of the state American Academy of Pediatricians (AAP), American Academy of Family Physicians (AAFP), Osteopathic Association, OSDH and OHCA. County and state survey results consistently identified extremely poor rates of return visits during a child's second year of life. The OK by One Project is being used to impact this finding. Preliminary results show an improvement in the proportion of children completing the 4th DtaP by 15 months of age. The results of a full evaluation should be available in 2006-07.

OSDH Immunization Field Consultants (IFC) continue to complete immunization audits in child care centers. Staff are working with centers to raise vaccine protection levels with a follow-up visit to centers falling below the 80% coverage level. Immunization representatives continue to target clinics in both the public and private sectors to be the recipients of CDC's AFIX intervention. AFIX is a proven method of practice level improvement.

The transition to the new web-based version of the OSIIS immunization registry has been completed. The new system is more user friendly, allows automatic generation of public vaccine orders and provides users with useful reports for improving the quality of care or identifying clinic immunization efforts.

c. Plan for the Coming Year

MCH will continue its close partnership with Immunization Service and support activities targeted toward attaining the goal of 90% of children up-to-date with the primary series of immunizations by their second birthday. Activities will continue to focus on support and evaluation of the OK By One Project, improved vaccination of child care attendees and clinic-level quality improvement. Efforts will also continue to expand private sector partnerships with business and medical communities to promote the health of children.

The OSDH will maintain its policy of providing immunizations to any child that presents at a county health department needing immunizations with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations are provided to an insured child, county staff will work with the parent/guardian to link the child with his/her primary health care provider for future immunizations.

A contractual agreement will remain in place between the OSDH and the OHCA allowing reimbursement for immunization services received through the county health department system for children covered by Medicaid. In addition, a contractual agreement will remain in place allowing reimbursement for Medicaid administrative costs related to the OSIIS.

MCH will continue to participate in the OSDH Immunization Advisory Committee that meets quarterly to update health care providers on current immunization issues and to seek input on ways to improve the system of care.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	33.4	31	30	29	28
Annual Indicator	32.5	31.2	28.6	27.4	27.4
Numerator	2490	2322	2216	2118	2118
Denominator	76531	74339	77409	77409	77409
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27.3	26.6	26	25.3	24.7

Notes - 2002

Birth data obtained from Health Care Information, Oklahoma State Department of Health. The number of births for year 2002 are considered provisional. Births for year 2001 have been revised to reflect current data. Population figures obtained from U.S. Census Bureau. Population data for years 2000-2001 reflect Census 2000 numbers.

Notes - 2003

PM#08: Birth data obtained from Health Care Information, Oklahoma State Department of Health. The number of births for year 2003 are considered provisional. Births for year 2002 have been revised to reflect current data. Population figures obtained from U.S. Census Bureau. Population data for years 2001 and 2002 have been revised with updated figures.

Notes - 2004

PM#08: Birth data obtained from Health Care Information, Oklahoma State Department of Health. The number of births for year 2004 are not yet available; therefore, year 2003 is repeated. Population figures obtained from U.S. Census Bureau.

a. Last Year's Accomplishments

The teen birth rate for this age group continues to decline in Oklahoma. This mirrors that found for the nation. In 2003, the latest year for which final data are available, the birth rate for teens aged 15 to 17 years was 27.4 births per 1,000 female population in this age group. Since year 2000, the birth rate has declined by 15% from 32.5.

Results of Oklahoma's first statewide-randomized Youth Risk Behavior Survey (YRBS) were widely disseminated. Of particular note, the Oklahoma State Department of Health (OSDH) Board of Health chose to focus the annual State of the State's Interim Health Report on key areas of concern from the YRBS. This report, released during a press conference at the State Capitol, highlighted adolescent pregnancy as one of these key areas of concern.

The Teen Pregnancy Prevention Fact Pack was updated and posted on the OSDH website as a resource to the public as well as state and community leaders about the current trends and prevention needs in regard to teen pregnancy prevention.

MCH participated on the Interagency Coordinating Council for the Prevention of Adolescent Pregnancy and STDs, a legislatively mandated council charged with implementing the state's strategic plan for the reduction of teen pregnancy and sexually transmitted infections. The Chief of MCH served as the designee for the Commissioner of Health with other MCH staff participating including the Women's Health Director and the Adolescent Health Coordinator. MCH also provided staff support for Council activities.

Funding and technical assistance continued to be provided to the 10 state-funded teen pregnancy prevention projects located across the state. Project Coordinators worked with adolescents using research-based curricula shown to be effective in reducing teen birth rates and also facilitated parent education sessions to provide assistance and resources to parents in how to talk about sexuality issues with their children. Evaluation of the projects was provided through a contract with the College of Public Health, University of Oklahoma Health Sciences Center. Again this year, statistically significant improvements were documented in all core areas with data quality at an all time high.

Emerson Teen Parenting Program in Oklahoma City and the Margaret Hudson Teen Parenting Program in Tulsa continued to receive MCH funding. Services provided included pre and post-natal care, school screenings, athletic physicals, immunizations, laboratory tests, general adolescent care, group mentoring for male and female youth, home visitation and peer education.

Comprehensive family planning services were provided, upon request by an adolescent, through county health departments and contract providers. Services included a comprehensive physical exam, education about contraceptive methods to include abstinence, provision of a contraceptive method, information on prevention of sexually transmitted infections and encouragement of parental involvement.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate Oklahoma Youth Risk Behavior Survey (YRBS) data to promote development of prevention activities.				X
2. Update Teen Pregnancy Fact Pack and use to inform local communities and state and local policy makers about the current trends and prevention needs in regard to teen pregnancy prevention.		X		
3. Participate in the Interagency Coordinating Council (ICC) for Prevention of Adolescent Pregnancy and Sexually Transmitted Diseases (STDs).				X
4. Provide funding and technical assistance to teen pregnancy prevention projects (TPPPs).				X
5. Provide funding and technical assistance to teen parenting programs.				X
6. Provide comprehensive family planning services through county health departments and contract clinics.	X			
7.				
8.				
9.				
10.				

b. Current Activities

The second statewide YRBS was accomplished this spring with results to be available in 2006. This will provide Oklahoma with data to compare with baseline data from the 2003 statewide YRBS.

The Teen Pregnancy Fact Pack (www.health.state.ok.us/program/ahd/factpack2004.pdf) is being updated to incorporate the most current Oklahoma and national vital statistics data. Of

particular interest is Oklahoma's rate in comparison with adjacent states. Historically, states to the north of Oklahoma (Colorado, Kansas and Missouri) have had lower rates, while other states (Arkansas, Texas and New Mexico) have had higher rates. This data will be posted on the agency website as a resource to inform the public as well as state and community leaders about the current trends and issues surrounding teen pregnancy prevention in Oklahoma.

MCH continues to participate on the Interagency Coordinating Council for the Prevention of Adolescent Pregnancy and STDs. The strategic plan for the state is currently being updated to reflect new research and trends in adolescent pregnancy and risk taking behavior.

An Invitation to Bid (ITB) was issued for a new five-year funding cycle (July 1, 2005 through June 30, 2010) for state-funded teen pregnancy prevention projects. A comparable application process was employed for county health department administered projects. Eight projects (four through private non-profits and four through county health departments) were funded.

An ITB was also issued for a new five-year funding cycle for a teen parenting program in the Tulsa area. This program is to provide health, education and social support services to adolescent parents with the intent of preventing subsequent unintended pregnancies and assuring high school completion.

The University of Texas, Southwestern Medical Center in Dallas, for the third straight year for advanced practice nurses and the second year for registered nurses, provided the opportunity for clinical skills update for staff providing reproductive health services through county health departments and contract providers. The two day onsite update, completed in February, was followed with up to 48 hours of online courses with continuing education approved for each course. This training was possible through a Title X Family Planning training grant.

c. Plan for the Coming Year

Data from the 2005 YRBS will be finalized in collaboration with the Centers for Disease Control and Prevention (CDC). This information will be compared to the baseline data obtained from the 2003 YRBS and results shared with the public as well as state and community leaders.

Differences in the states to the north of Oklahoma will be explored by MCH in an effort to determine whether there are interventions that may be appropriate to implement with like populations in Oklahoma.

The Teen Pregnancy Fact Pack will be updated and information used in educating state and community leaders. The information will also be posted on the agency website as a resource on the current trends and issues surrounding teen pregnancy prevention in Oklahoma.

MCH will continue to participate on the Interagency Coordinating Council for the Prevention of Adolescent Pregnancy and STDs. MCH will also continue to provide funding and staff support of council activities to facilitate implementation of the state plan.

Technical assistance will be provided to the eight state-funded teen pregnancy prevention projects located across the state. The teen pregnancy prevention projects will lead community coalitions with the purpose of building community capacity to address the issue of teen pregnancy and providing a community environment conducive to delaying early sexual involvement. As part of the Invitation to Bid requirements, these projects will coordinate their coalition activities with local Turning Point partnerships, which are part of a statewide Council that addresses public health using a coordinated community development model. These projects will work with adolescents utilizing research-based curricula shown to be effective in delaying sexual activity. The projects will also provide parent education sessions wherein parents will be provided assistance and resources on how to talk about sexuality issues with

their children. Evaluation of the teen pregnancy prevention projects will be provided by the College of Public Health, University of Oklahoma Health Sciences Center.

The Emerson Teen Parenting Program in Oklahoma City and the Margaret Hudson Teen Parenting Program in Tulsa will continue to receive support from MCH. Services will include pre and post-natal care, school screenings, athletic physicals, immunizations, laboratory tests, general adolescent care, group mentoring for male and female youth, home visitation and peer education.

Comprehensive family planning services will continue to be provided, upon request by an adolescent, through county health departments and contract providers. Services will include a comprehensive physical exam, education about contraceptive methods to include abstinence, provision of a contraceptive method, information on prevention of sexually transmitted infections and encouragement of parental involvement.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23	24	25	26	40
Annual Indicator	22.0	22.0	22.0	37.2	32.9
Numerator	21069	21054	22329		
Denominator	95769	95700	101495		
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	41.2	42.4	43.7	45	46.4

Notes - 2002

For previous reportings, this measure was estimated by using data from the Oklahoma First Grade Survey generalized to the population of Oklahoma third graders.

OSDH Dental Services has contracted with the University of Oklahoma College of Dentistry to perform a focused assessment of third grade children. The Department of Biostatistics and Epidemiology, University of Oklahoma College of Public Health is collaborating with Dental Services to determine sample design and to perform the data analysis. Results are anticipated for later this year (2003). When these results are made available, the performance measure will be updated.

Notes - 2003

PM#09: 2003 data were obtained from Oklahoma Oral Health Needs Assessment, 2003 -

Dental Health Service, OSDH.

Notes - 2004

PM#09: Data were obtained from a statewide Oklahoma Oral Health Needs Assessment, 2004 - Dental Health Service, OSDH.

a. Last Year's Accomplishments

Using Title V MCH funds, the Oklahoma State Department of Health (OSDH) Dental Service contracted with the University of Oklahoma (OU) College of Dentistry to conduct the 2004 dental needs assessment and worked with the OU College of Public Health, Department of Biostatistics and Epidemiology to determine the sample design and complete the data analysis. Comparison of data from the 2004 dental needs assessment to the 2003 dental needs assessment demonstrated: 32.9% of third grade children having protective sealants on at least one permanent molar tooth in 2004 compared to 37.2% in 2003; 73.6% of third grade children having dental caries experience in 2004 compared to 69.4% in 2003; 38.3% of third grade children having untreated dental decay in 2004 compared to 40.2% in 2003; and, on an average, each third grade child having 2.9 teeth that were decayed or had been decayed compared to 2.8 in 2003.

MCH continued to work collaboratively with the Dental Service to educate children, their parents/guardians, and health care providers on oral health to include the importance of protective sealants. The MCH School Health Program distributed dental and oral health education material via schools, newsletters and conferences. Child health providers obtained dental histories and assessed teeth during well child care exams and referred as indicated. The Healthy Child Care Oklahoma Project assured that child care providers received information on oral health issues.

Dental education services included dental health education and tobacco use prevention instruction in 33 counties. The educators reached 36,178 children, child care through high school, with emphasis on kindergarten through sixth grades. Topics included appropriate dental hygiene and care of one's teeth, playground safety, the use of mouth guards, dental disease prevention (sealants, fluoridation, regular dental care) and proper nutrition with healthy snacks.

Title V MCH funds also supported dental clinical services provided to children through seven county health department sites. Procedures and services included dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction and prescriptions for infections.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Dental Service on annual accomplishment of the dental health needs assessment and on use of data to impact policy and services.				X
2. Provide dental health education through schools and child care facilities to children and teachers.			X	
3. Provide dental health education and screenings during well child visits provided at county health departments or contract clinics.	X			
4. Provide clinical dental health services through county health departments.	X			
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

A written report of the 2004 statewide dental needs assessment of third grade children is in the process of being finalized. Based on the findings of the needs assessment, the Dental Service has made the following recommendations to improve the oral health of Oklahoma's children: increase efforts to educate the public about the importance of oral health as part of total health; increase access to dental care for children eligible for Medicaid; emphasize the importance of dental sealants for children to both the public and private dental professionals; increase the number of fluoridated public water systems in Oklahoma; and, decrease the incidence of tobacco use to reduce oral lesions and oral disease.

The 2005 statewide dental needs assessment of third grade children is currently being conducted. The Dental Service is working with the OU Colleges of Dentistry and Public Health to complete this project.

Dental education services in 33 counties and dental clinical services in seven county health department clinic sites continue to be provided.

The dental clinic at the Cleveland County Health Department in Norman has been reopened and new dental equipment purchased for the clinic. A community open house was held in April 2005 to celebrate the opening of this needed clinic.

c. Plan for the Coming Year

The annual dental needs assessment of third grade children will be conducted by the Dental Service working with the OU Colleges of Dentistry and Public Health. The needs assessment will be accomplished using licensed Oklahoma dentists to screen children. Information obtained from this needs assessment is planned to include both dental caries and dental sealant data. The results will be reported as has been done previously upon the completion of the survey.

Dental education program services will be continued. Topics will include appropriate dental hygiene and care of one's teeth, playground safety, the use of mouth guards, dental disease prevention (sealants, fluoridation, regular dental care) and proper nutrition with healthy snacks.

Dental clinical services (dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction, and necessary prescriptions for infections) will continue to be provided to children in need in selected county health departments. It is anticipated that the dental clinic at the Pottawatomie County Health Department will be reopened during 2006 to help provide access to needed dental clinical services.

Staff in county health departments and contract clinics will continue to obtain dental histories and assess oral health during well child exams and refer as indicated. The MCH School Health Program will continue to distribute dental and oral health education material at schools, through statewide school newsletters and at conferences. Dental health will be part of the health issues addressed as MCH provides support for the implementation of the state's comprehensive plan for early childhood.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.1	6.9	6.7	6.5	4.5
Annual Indicator	3.8	6.1	4.5	3.8	3.8
Numerator	28	45	33	28	28
Denominator	733102	733102	733102	727566	727566
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.7	3.7	3.6	3.6	3.5

Notes - 2002

Vital statistics data were obtained from Health Care Information, Oklahoma State Department of Health. Population figures reflect Census 2000 numbers.

Notes - 2003

PM#10: Data were obtained from Health Care Information, OSDH.

Notes - 2004

PM#10: Data were obtained from Health Care Information, OSDH. Data for year 2004 are not yet available; therefore, year 2003 is repeated.

a. Last Year's Accomplishments

In 2003, the latest year for which final mortality data are available, there were 28 reported motor vehicle deaths to children under the age of 15 years, resulting in a death rate of 3.8 per 100,000 children in this age group. This marks the second straight year for which this measure had declined. In 2001, the death rate stood at 6.1 per 100,000 population, a decline of nearly 38%. This should be viewed cautiously however. The small number of events tends to make interpretation of rate changes problematic. That is, rates are prone to year-to-year fluctuation due to the small number of events occurring in the measure under study.

A close working relationship with the Oklahoma State Department of Health (OSDH) Injury Prevention Service was maintained. MCH and Injury Prevention staff collaborated on strategic planning, task forces and trainings to impact the prevention of unintentional injuries to include motor vehicle crashes.

The Healthy Child Care Oklahoma Project continued collaborative work with the Oklahoma Department of Human Services (OKDHS) Child Care Licensing Division. A particular focus was the enforcement of the more stringent licensing requirement for safely transporting children in child care that became effective in August 2003. The requirement assures that all children must be in child safety/booster seats at least until they enter kindergarten.

The OSDH continued to be the lead agency for the partnership with the National SAFE KIDS Campaign. MCH continued to provide state level leadership and administrative support for the Oklahoma SAFE KIDS Coalition (SAFE KIDS). SAFE KIDS continued as a collaborative partnership among the OSDH, University of Oklahoma (OU) Children's Physicians, the OU Medical Center, the Oklahoma Highway Safety Office and SAFE KIDS Inc., a private non-profit fund raising arm of the Coalition.

SAFE KIDS successfully educated legislators to gain their support for an amendment to Oklahoma's child passenger safety law. The measure was signed into law on March 31, 2004. The law requires all children under age 6 to be restrained in a child safety seat or booster seat.

Child passenger safety trainings, child safety seat check-up events, technical assistance to parents/caregivers and presentations on child passenger safety were provided by SAFE KIDS. In addition, SAFE KIDS subsidized the cost of child safety seats for low-income families, distributed free seats at public events and maintained its loaner car seat program for children with special health care needs.

Please Be Seated, an initiative of SAFE KIDS accomplished through a partnership with the Oklahoma Highway Safety Office, continued to notify individuals carrying unrestrained children in their vehicles with a letter and information on how to obtain a free or discounted car seat. An average of 89 letters per month was sent to reported violators.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with OSDH Injury Prevention Service on prevention activities to reduce deaths from motor vehicle crashes.				X
2. Collaborate with the OKDHS Child Care Licensing Division on policy and procedures to assure safe transportation of children in child care settings.				X
3. Provide leadership and support for the Oklahoma SAFE KIDS Coalition. Work in partnership with the University of Oklahoma (OU) Children's Physicians, the OU Medical Center, Oklahoma Highway Safety Office and SAFE KIDS Inc to support the Coalition.				X
4. Support activities of SAFE KIDS: educational events, trainings, provision of child safety seats, loaner program for children with special health care needs and Please Be Seated initiative.				X
5.				
6.				
7.				
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9.				
10.				

b. Current Activities

Multiple strategies (e.g. collaboration with state and local partners, the School Health Newsletter, press releases, trainings for schools and child care providers, exhibits at conferences, sharing of information through listservs) are being used by MCH in continued efforts to reduce motor vehicle injuries and deaths to children.

With a growing demand for the availability for car seats for low-income families, MCH realigned funding this year to enable purchasing of car seats for distribution through SAFE KIDS.

SAFE KIDS members and volunteers successfully advocated for an amendment to Oklahoma's child passenger safety law during the 2005 legislative session. The amendment raises the fine from $25 to $50 plus court costs.

An educational video was produced on the 2004 amendment to the state's child passenger safety law. The amendment increased the age that children must be transported in a child safety seat from all children under age 4 to all children under age 6. This amendment, plus basic tips on proper use, was summarized in a video distributed to law enforcement agencies in the state.

In May 2005, for National SAFE KIDS Week, SAFE KIDS facilitated participation of injury prevention programs from across the state in Safety Day at the Capitol as an advocacy effort to raise awareness of preventable injuries to include motor vehicle accidents.

The MCH SAFE KIDS Coordinator and the Early Childhood Comprehensive Systems (ECCS) Coordinator are in discussions with the Oklahoma Department of Human Services (OKDHS) Child Care Advisory Board regarding a mandatory educational component for all child care centers on proper use of child safety seats.

c. Plan for the Coming Year

Data obtained from the 2005 statewide-randomized YRBS will be shared with the public as well as state and community leaders to enhance prevention activities. In addition, MCH will continue to provide information on the importance of routine safety restraint usage utilizing school health monthly resource packets, quarterly school health newsletters, the Good Health Gets an A Calendar and information booths at conferences. Technical assistance and trainings will continue to be provided to child care facilities.

The OSDH will continue to be the lead agency for the partnership with the National SAFE KIDS Campaign. MCH will continue to provide state level leadership and administrative support for SAFE KIDS. SAFE KIDS will continue as a collaborative partnership among the OSDH, OU Children's Physicians, the OU Medical Center, the Oklahoma Highway Safety Office and SAFE KIDS Inc., a private non-profit fund raising arm of the Coalition.

The MCH ECCS Coordinator will serve on the OKDHS Child Care Advisory Board. The Board recommendation, that one person in each licensed child care center (about 2,000 centers in the state) would have to complete the eight-hour "Introduction to Child Passenger Safety" course, has been forwarded to the OKDHS Commission for review and approval. If approved, it is anticipated that SAFE KIDS will coordinate classes for child care providers.

The Please Be Seated Project, accomplished in partnership with the Oklahoma Highway Safety Office, will continue to allow concerned citizens to report, via postcard, vehicles carrying unrestrained children. The motorist will be contacted by mail and provided helpful information regarding acquisition of free or reduced price car seats for their children. Collaborative activities with car dealerships, television stations, insurance companies and other agencies focused on preventive education on car seat safety will also continue statewide.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	67	68	69	70	72.5
Annual Indicator	68.1	70.7	68.0	68.9	68.9
Numerator	31993	35369	34210	35052	35052
Denominator	46980	50027	50310	50874	50874
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73.6	74.7	75.8	76.9	78.1

Notes - 2002

The estimate for the prevalence of mothers breastfeeding at discharge was obtained from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). The obtained estimate is then applied to the number of total resident Oklahoma births to achieve numerator data. The estimate reflects data from the year 2000 Prams, the most recent figures available. Data previously reported for years 2000 and 2001 have been revised to reflect current information.

Birth data were obtained from Health Care Information, Oklahoma State Department of Health.

Notes - 2003

PM#11: Data were obtained from Oklahoma PRAMS.

Notes - 2004

PM#11: Data were obtained from Oklahoma PRAMS. Year 2004 data are not yet available. Year 2003 estimate is repeated.

a. Last Year's Accomplishments

MCH monitored breastfeeding activity through data received from the Pregnancy Risk Assessment Monitoring System (PRAMS) and Women, Infants and Children supplemental nutrition program (WIC). The PRAMS, a Centers for Disease Control and Prevention (CDC) population-based surveillance system, provided data on the percentage of mothers who breastfed their infants at hospital discharge. The WIC information system provided data on the duration of breastfeeding for clients served by this supplemental nutrition program. PRAMS data for 2003 revealed 68.9% of mothers initiate breastfeeding sometime after delivery. This finding is largely unchanged in recent years. Multi-year data from PRAMS for year 2000-2002 indicate a similar result of 68.9% for initiation of breastfeeding after delivery with 29.6% of those mothers who initiate breastfeeding continuing for 2-8 weeks and 60.7% of those who initiated breastfeeding continuing beyond 2 months. WIC data showed the average duration of breastfeeding in clients utilizing the supplemental nutrition program was between 1-2 months with 25.6% of mother's breastfeeding at least 6 months and 7.5% of mother's breastfeeding beyond 6 months.

The MCH Family Advocate provided leadership for the activities of the Central Oklahoma Breastfeeding Advocates (COBA). The group included community members, La Leche League,

hospitals, WIC lactation consultants, physicians, nurses, nutritionists, representatives from the Central Oklahoma Perinatal Coalition and professionals who are interested in promoting breastfeeding.

A two-hour videoconference training entitled "Counseling on Breastfeeding Success" was provided to county health department and contract agency service providers on March 15, 2004. The objectives of this training were to assist clinic staff in identifying ways to counsel new mothers about breastfeeding and help them to be successful throughout the infant's feeding period.

MCH drafted language for legislation passed to support, promote and protect a mother's right to breastfeed, exempting this activity from public indecency laws. The legislation also gave breastfeeding mothers the ability to opt out of jury duty if doing so interfered with their ability to successfully breastfeed.

The University of Oklahoma Health Sciences Center (OUHSC) Perinatal Continuing Education Program (PCEP), a statewide program for hospital based medical and nursing staff funded through MCH, continued to make their breastfeeding education curriculum available to all physicians and nurses to improve their knowledge and expertise in encouraging pregnant women to breastfeed.

The OSDH breastfeeding room was completed to provide onsite facilities for breastfeeding employees and visitors. Breastfeeding mothers now have an accessible, private location to breastfeed their infants.

Advanced practice nurses and nurses in county health departments and contract sites provided education and support to breastfeeding mothers receiving services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor breastfeeding through data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and Women, Infants and Children supplemental nutrition program (WIC).				X
2. Provide leadership and support activities of the Central Oklahoma Breastfeeding Advocates (COBA)				X
3. Train health care providers at county health departments and contract sites on ways to counsel new mothers about breastfeeding to promote the success of breastfeeding.				X
4. Provide leadership in drafting state policy for breastfeeding.				X
5. Support the Perinatal Continuing Eduation Program (PCEP) to train hospital medical and nursing staff.				X
6. Provide leadership for completion of the OSDH breastfeeding room and assist employees with use of the onsite benefit.		X		
7. Provide education and support to pregnant women planning to breastfeed and mothers breastfeeding through staff providing services in county health department and contract sites.		X		
8.				
9.				

10.				

b. Current Activities

Part one of a two-part PRAMSGRAM has been published and distributed to inform and educate health care providers and state and community leaders further about breastfeeding in Oklahoma. This PRAMSGRAM defines Oklahoma breastfeeding initiation rates and addresses factors influencing the decision to initiate breastfeeding. It also contains an insert "Breastfeeding Tips for Moms" that can be copied by health care providers and given to women who are breastfeeding. Part II is currently in draft form and expected to be published and distributed by late summer. It will define duration rates and address factors influencing breastfeeding duration in Oklahoma.

A MCH Nutritionist was hired in December 2004. This staff works closely with MCH programs in the development of program services and has recently completed a Breastfeeding Educator Course.

Collaboration with the COBA continues with involvement of the MCH Nutritionist and the MCH Family Advocate. This group has been instrumental in passage of House Concurrent Resolution No. 1015 this year by the state legislature. The House Resolution encourages the State of Oklahoma and all Oklahoma employers to support and encourage breastfeeding by ensuring that employees who are nursing have adequate facilities and support.

c. Plan for the Coming Year

Breastfeeding rates will continue to be monitored by MCH through data received from the PRAMS and WIC. This information will be used in development of program services and with women, families, health care providers and community groups to promote and foster the success of breastfeeding.

Use of billboards and benches in communities will be explored by MCH as a strategy to display positive messages about the benefits of breastfeeding. MCH will also look to strengthen linkages with childbirth educators in the state to enhance positive breastfeeding experiences for mothers, infants and their families. These have been particular areas of interest for the MCH Family Advocate who will provide leadership along with the MCH Nutritionist for these activities.

State level focus on decreasing barriers to breastfeeding will remain a priority as MCH continues work with COBA and the state perinatal coalition, Healthy Mothers/Healthy Babies.

The MCH Nutritionist will provide technical assistance to MCH programs, Children First, local family resource and support programs and the Healthy Start projects. Educational materials on breastfeeding will be identified and developed for health care providers to use with clients.

Education on the importance of adequate nutrition and healthy weight gain during pregnancy to enhance readiness for breastfeeding and continued attention to adequate nutrition after delivery while breastfeeding will be provided to pregnant women seen in maternity clinics. Advanced practice nurses and nurses in county health departments and contract sites will continue to provide education and support to breastfeeding mothers.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	70	80	90	93.5
Annual Indicator	59.5	90.0	92.6	96.2	96.2
Numerator	29583	45445	45174	48928	48928
Denominator	49680	50494	48764	50874	50874
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96.6	97.2	97.7	98.1	98.6

Notes - 2002

Data for PM#12 were obtained from the Newborn Hearng Screening Program, Screening and Special Services, Oklahoma State Department of Health.

Notes - 2003

PM#12: Data were obtained from Screening and Special Services, OSDH.

Notes - 2004

PM#12: Data were obtained from Screening and Special Services, OSDH. Data for year 2004 are not yet available, therefore, the previous year's indicator has been used to generate estimates. Performance Measure will be updated as new information is released.

a. Last Year's Accomplishments

In calendar year (CY) 2003, all newborn hearing screening records were entered into the recently created combined newborn hearing/newborn metabolic disorder database. Of the 50,874 Oklahoma births in CY 2003, 48,928 infants (96%) had hearing screened prior to hospital discharge and 1,946 were not screened. Of the infants screened, 1,579 (3%) were referred for diagnostic assessment. Of the infants who referred, 69 were found to have significant hearing loss. Because of the presence of "risk indicators for hearing loss," 2,757 infants who passed screening at birth were referred for additional hearing screening when they reached six months of age. At least 44 infants with a diagnosis of hearing loss born in 2003 and 20 infants born in 2004 were enrolled in early intervention programs for infants with hearing loss as of September 30, 2004.

On October 1, 2003, seventy-six (76) Oklahoma birthing facilities were providing physiologic hearing screening. Ten (10) facilities closed their birthing units during 2004 and one hospital re-opened its previously closed unit. All sixty-seven (67) Oklahoma birthing facilities with a census of fifteen or more births per year were providing physiologic hearing screening on September 30, 2004.

Through collaboration with the Oklahoma Chapter, American Academy of Pediatrics (OKAAP), the issue of how to screen infants born at home or in a hospital with a birth census of less than 15 continued to be addressed. The OKAAP's hearing screening "Chapter Champion" kept fellow physicians fully informed about the necessity of such screening for infants not screened at birth and the availability of physiologic screening at county health departments.

Approximately 500 nurses and other clinicians received training in how to correctly complete the combined newborn hearing/newborn metabolic disorder screening form. In January 2004, an additional page was added to the bloodspot screening form to provide the hospital with a copy of the demographics and hearing results for the infant's medical record.

The Maternal and Child Health Bureau (MCHB) "Oklahoma Universal Newborn Hearing Screening and Intervention Project," entered its fourth and final year. Funds provided for 16 additional portable physiologic screening devices and a contract with Neometrics to integrate the newborn screening database with the immunization database.

The NHSP task forces met regularly. The Audiology Task Force focused on assuring Medicaid eligible infants were fit with appropriate amplification in a timely manner and that reimbursement to audiologists was appropriate. The Early Intervention Task Force took steps to assure that various methodologies of intervention were available to deaf and hard of hearing infants at no cost to the family. The Screening Task Force distributed brochures in English and Spanish describing newborn hearing screening to mothers who delivered at the birthing facilities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide hearing screening to all newborns born in Oklahoma birthing facilities.			X	
2. Collaborate with Oklahoma Chapter, American Academy of Pediatrics on strategies to assure infants born at home or in a hospital with a birth census of less than 15 receive hearing screening.				X
3. Train health care providers on combined newborn hearing/newborn metabolic disorder screening form to assure accurate completion of data.				X
4. Purchase additional diagnostic audiometers for county health departments and early intervention sites.				X
5. Continue activities to link newborn screening database with immunization database to assist with location/follow-up with families.				X
6. Address ongoing issues of access to services/equipment, reimbursement for services and education of families through Newborn Hearing Screening Program (NHSP) Task Forces.				X
7.				
8.				
9.				
10.				

b. Current Activities

The NHSP is working closely with the Oklahoma Hospital Association to ascertain the CSHCN funded physiologic hearing screening equipment is in place at all state birthing facilities requesting it and that staff at these sites are appropriately trained to screen the hearing of all newborns.

MCH, the CSHCN Program and the NHSP are exploring ways to obtain ongoing sustained funding to begin replacing hospital screening equipment as some of the screening equipment originally purchased with CSHCN funds is approaching the end of its useful life. A plan has

been developed recommending replacing the ninety hearing screening units at eighteen a year over five years.

The NHSP task forces, Screening, Audiology, and Early Intervention, meet regularly to address a number of issues. The Screening Task Force is taking steps to assure that hospital hearing screening refer rates continue to stay at 3% or less. This task force is working closely with the Oklahoma Hospital Association in an effort to assure that hospitals are appropriately reimbursed for the screening they perform. The Audiology Task Force has developed a "hearing" resource manual to be given to all Oklahoma audiologists. The notebook includes information about hearing loss, intervention strategies and services for deaf and hard of hearing children that can be reproduced easily and given to parents of newly diagnosed deaf infants and children. The Early Intervention Task Force is focusing on how to assist families with the transition from the 0 to 3 program into one for older deaf and hard of hearing children. Through the efforts of this task force, SoonerStart, Oklahoma's early intervention program for 0 to 3 year olds, hired deaf education coordinators for several areas of the state.

The MCHB grant funds for the Oklahoma Universal Newborn Hearing Screening and Intervention Project that began March 31, 2001 extended through March 30, 2005. The combined newborn hearing/newborn metabolic disorder screening database is linked with Vital Records and is currently being linked with the immunization database. This is enhancing tracking capabilities of infants with possible hearing loss and reducing the number of infants lost to follow-up. Statistical reports indicating the number of infants who had hearing screened, who referred on the hospital screening and who are diagnosed with hearing loss is now available in a timely manner. Both the English and Spanish versions of the parent brochure explaining newborn hearing screening have been reprinted and continue to be distributed to Oklahoma birthing facilities, county health departments as well as public and private clinics.

The NHSP has been awarded a new MCHB universal newborn hearing screening grant. The new project began April 1, 2005 and runs for three years. Grant funds are being used to hire additional personnel for the NHSP, upgrade diagnostic audiologic equipment and further enhancement of the tracking system.

c. Plan for the Coming Year

MCH and the CSHCN Program will continue to work closely with the NHSP. MCH will continue to provide Title V funding to support ongoing statewide newborn hearing screening activities with both MCH and the CSHCN Programs providing technical assistance when needed.

The NHSP task forces, Screening, Audiology and Early Intervention, are expected to continue their ongoing activities. While some progress has been made in obtaining Medicaid reimbursement for hospital hearing screening, the Screening Task Force will continue to address that issue to be certain that reimbursement approaches the actual cost of performing the procedure. The task force will also explore possible sources of funding to replace the five to seven year old hospital screening equipment. New equipment may be necessary to assure that refer rates stay at an appropriately low level. The Audiology Task Force will review the current Oklahoma protocols for infant diagnostic assessment and infant hearing aid assessment. It will further explore whether screening for auditory neuropathy/dis-synchrony should be part of the newborn screening procedure. It is expected that the Early Intervention Task Force will continue to address better ways to assist families with the transition from SoonerStart at age three to other educational programs. Through the efforts of this group, updated Ski-Hi training will be made available to SoonerStart clinicians working with deaf and hard of hearing infants.

With support made available through the MCHB funded Universal Newborn Hearing Screening Project, April 2004 through March 2008, an additional staff person will be added to the NHSP. About 40% of the infants who refer on the hospital screening or are not screened at birth are

lost to follow-up by the tracking system. Current staffing patterns do not allow program personnel to spend time finding these families. It is anticipated that having an additional staff person will assist the NHSP in reaching the national MCHB goal of assuring that every newborn is screened within the first month of life and that infants with a loss are diagnosed and enrolled in intervention by three months of age. Funding from this source will be used to upgrade the oto-acoustic emission diagnostic equipment located at health department audiology locations and to enhance the newborn screening tracking system.

The NHSP will continue to provide appropriate educational opportunities for hospital staff regarding newborn hearing screening techniques and procedures. Training in using hearing screening/diagnostic equipment as well as updates on screening and assessment techniques will be offered to health department clinicians and other interested health care professionals.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	21	20.5	20	19.5	14
Annual Indicator	17.2	17.2	17.0	14.1	15.3
Numerator	175283	175142	160321	130150	141860
Denominator	1019085	1018268	943066	926120	924670
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.7	13.4	13.1	12.8	12.6

Notes - 2002

The estimate for the percent of Oklahoma children without health insurance was obtained from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Estimates are pooled March 2001 and 2002 Current Population Surveys.

Notes - 2003

PM#13: Data were obtained from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002 and 2003 Current Population Surveys.

Notes - 2004

PM#13: Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys.

a. Last Year's Accomplishments

According to published reports from the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, and Kaiser Foundation, a total of 15.3% of Oklahoma children 18 years and younger were uninsured in 2004. This is a modest decline from year 2000 in which the Kaiser

Foundation estimated the uninsured rate for children at 17.2%.

The Oklahoma Areawide Services Information System (OASIS) continued as the Title V statewide 1-800 central toll-free telephone information/referral line with access to information also available through the OASIS website (http://oasis.ouhsc.edu). The Joint Oklahoma Information Network (JOIN), a partnership of state agencies with the shared vision of providing improved, personalized access to government assistance programs, continued to integrate the OASIS into the network as a centralized resource and referral service statewide.

County health departments and MCH contract providers worked with families to provide them with information on Medicaid, to successfully complete Medicaid applications and to connect families to providers accepting Medicaid.

The MCH Early Childhood Comprehensive Systems (ECCS) Project continued to focus on bringing together existing state initiatives and efforts to develop one state plan for early childhood. The MCH ECCS Coordinator continued to provide leadership and support to the legislatively mandated Oklahoma Partnership for School Readiness (OPSR) Board and other stakeholders to assure that as the planning process continued all five of the critical components of the ECCS grant were addressed as focus areas within the plan. Access to health insurance and medical homes for all children is one of the five key areas of focus.

The Chief of MCH and other MCH staff continued to serve as members of the Oklahoma Child Death Review Board. The Board looked at multiple variables that led to child death including the lack of access to health services and inadequate coverage for the families experiencing the loss of a child. The Board made legislative and administrative recommendations as a result of reviewing the deaths that occurred.

Clinical services were provided as a safety net and gap filling service through county health departments and contract providers with 14,012 children (2240 <1 year of age and 11,772 1-21 years of age) receiving services during state fiscal year (SFY) 2004. Tulsa and Oklahoma metropolitan areas, continued to see an increased number of undocumented Hispanic children. Services continued to be provided in accordance with the American Academy of Pediatrics and the Bright Futures guidelines. Comprehensive care included: comprehensive histories and physical examinations, developmental and nutritional screenings, immunizations, injury prevention education, lead screening, treatment of minor illnesses and anticipatory guidance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain support for the Title V statewide 1-800 central toll-free telephone information/referral line to include integration of this service into the Joint Oklahoma Information Network (JOIN).				X
2. Provide leadership for the state Early Childhood Comprehensive Systems (ECCS) Project - access to health insurance is one of the five key areas of focus.				X
3. Participate in the Oklahoma Child Death Review Board and provide technical assistance and consultation on issues that arise related to access to health services and inadequate health insurance coverage.				X
4. Link families with Medicaid through assisting with completion of applications and connecting families with providers accepting Medicaid.		X		
5. Provide child health clinical services as a safety net provider through				

county health departments and contract providers.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Earlier this year, MCH linked with the JOIN, a collaborative initiative among state agencies to build a common internet-based data repository and vehicle to share information across agencies to facilitate individuals and families receiving needed services, by assuring access to current eligibility and availability information on health services for children via linkages to the Oklahoma State Department of Health (OSDH) MCH web page.

The MCH ECCS Coordinator continues to assure that health insurance status and medical home are being addressed as the state plan for early childhood is developed. It is anticipated that the plan will be finalized by the end of the planning grant phase in August 2005.

MCH continues to be involved in looking at the health needs of homeless families with children in the state. The Director of the MCH Child and Adolescent Health Division serves on the Governor's Interagency Council on Homelessness. Work continues on refining and implementing a state plan.

Efforts of the Oklahoma Primary Care Association and the OSDH Office of Primary Care to expand federally qualified health centers (FQHCs) in Oklahoma to serve the needs of the uninsured and underinsured are being supported by MCH. There are currently eight FQHCs in Oklahoma operating 17 access sites. The expansion of FQHCs will provide a more adequate system for comprehensive health care for uninsured and underinsured children. During this year's legislative session, over $2 million was appropriated to support existing FQHCs and expand Oklahoma FQHCs. Oklahoma also received $2.85 million for four new community health centers from the Health Resources and Services Administration, Bureau of Primary Health Care.

MCH continues to work with the Oklahoma Institute for Child Advocacy (OICA) in statewide efforts to impact the uninsured. MCH disseminated information and encouraged community involvement in activities for "Cover the Uninsured Week" in March 2005. The Chief of MCH serves on the OICA Health Advisory Board. The priority of this Board has been to reach out to uninsured families and link them with Medicaid. With Robert Wood Johnson funding to support this effort ending this year, the Board remains committed to continuing to assure that health care is available to all children in the state.

In March, a Tulsa federal judge ruled that Oklahoma physicians who treat young Medicaid clients must be reimbursed the same amount of money as they would receive for treating senior citizens covered by Medicare. The judge ordered that reimbursement changes must occur in six months. A related outcome of this ruling is the OHCA convening a state level work group this summer to explore immediate actions to be taken to improve the state's Medicaid services for children. The Chief of MCH is part of this work group that will focus initially on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

c. Plan for the Coming Year

The OASIS will continue to serve as the Title V statewide 1-800 central toll-free telephone information and referral service. As JOIN continues to move forward in integrating the OASIS

into the network, MCH will continue to provide support and technical assistance.

County health department and contract providers will continue to assist families with completion of the Medicaid application and linkage to needed services.

MCH will administer the First Grade Health Survey in 2006. Information from this population-based survey of parents of first grade students in public schools will be used (along with information from The Oklahoma Toddler Survey, a follow-up population-based survey of two year olds whose mothers were surveyed through the Pregnancy Risk Assessment Monitoring System (PRAMS), and the statewide annual dental health needs assessment) in education of state and community-based policy makers and health care providers to support systems changes to enhance access to insurance coverage for health care including dental care services for children.

The state's ECCS plan will move into the implementation phase. The MCH ECCS Coordinator will continue to provide leadership and support to this statewide initiative. One of five key areas of focus is access to health insurance and medical homes for all children.

MCH will partner with the OICA in developing the children's agenda for the 2006 legislative session. The focus for the 2005 Fall Forum is "children's health". This agenda will be finalized during the annual Fall Forum, an event that brings child advocates from the state, regional, county and community levels together to focus on children's health issues.

MCH will continue to participate in the work group initiated by the OHCA to identify and implement improvements to its Medicaid program for children. MCH will also monitor implementation of the Premium Assistance Program. Pending Centers for Medicare and Medicaid Services (CMS) approval, October 1, 2005 is the target date identified for initiating the first phase of this program that is being implemented under a Health Insurance Flexibility and Accountability (HIFA) Waiver. This first phase of the Premium Assistance Program allows persons who work for employers with less than 25 employees to become Medicaid eligible if household income is less than 185% FPL. The client has to pay a portion of the insurance premium and the employer has to pay a portion of the insurance premium.

MCH will continue to work closely with the Oklahoma Primary Care Association and the OSDH Office of Primary Care as technical assistance and support is provided to communities implementing or applying for FQHCs.

Child and adolescent health clinical services will be provided as a safety net service through county health departments and contract providers for uninsured and underinsured children. Services will be provided in accordance with the American Academy of Pediatrics and Bright Futures guidelines.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	78	79	80	81	82.2
Annual Indicator	64.5	75.9	79.0	78.2	77.4
Numerator	255315	301016	338727	343243	385620
Denominator	396000	396424	429000	438700	498031
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83.9	85.6	87.3	89	90.8

Notes - 2002

Numerator data for PM#14 were obtained from the Oklahoma Health Care Authority. Denominator data were obtained from the Kaiser Family Foundation, the Kaiser Commission on Medicaid and the Uninsured. Data for years 2000 and 2001 have been updated with newly gained information.

Notes - 2003

PM#14: Data were obtained from the Oklahoma Health Care Authority and the Kaiser Foundation.

Notes - 2004

PM#14: Data were obtained from the Oklahoma Health Care Authority and the Kaiser Foundation.

a. Last Year's Accomplishments

According to the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, 77.4% of the Medicaid eligible children received a service paid by Medicaid. After a number of years in which this measure had increased, Oklahoma has experienced a leveling off on the percent of Medicaid eligible children receiving a paid service from the state's Medicaid program.

County health department staff continued to work with families to provide them with information on Medicaid, to successfully complete Medicaid applications and to connect families to providers accepting Medicaid. Contractual language in the MCH fixed rate service contracts with providers and the CSHCN Program service provision contracts continued to require contract providers to assist families with the Medicaid application process in order to enhance the success of families in applying for and in accessing Medicaid.

MCH continued to work with schools and child care facilities to share information for families on Medicaid eligibility, the application process and to connect children and their families with Medicaid providers for health care services.

The Chief of MCH continued to participate on the Oklahoma Institute for Child Advocacy (OICA) Health Advisory Board. The major focus of the group continued to be outreach and the enrollment of children in Medicaid and the State Children's Health Insurance Program (SCHIP).

MCH completed its first year of the Maternal and Child Health Bureau (MCHB), Early Comprehensive Childhood Systems (ECCS) Planning Grant. The MCH ECCS Coordinator focused on providing infrastructure support to the planning activities of the state to develop one state level early childhood plan. The MCH ECCS Coordinator collaborated closely with the Oklahoma Partnership for School Readiness (OPSR), a legislatively appointed Board mandated to improve the early childhood system in the state to assure that all children are

healthy and ready to learn upon school entry, and other early childhood initiatives in the state to assure a comprehensive plan evolved. A key focus area in planning was assuring all children have access to health coverage.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist individuals and families with enrollment in Medicaid at the community level.		X		
2. Maintain clause in MCH and CSHCN contracts requiring assistance with Medicaid enrollment.		X		
3. Provide technical assistance to schools and child care providers on outreach and Medicaid.				X
4. Participate in the Oklahoma Institute for Child Advocacy (OICA) Health Advisory Board - focus is on outreach and enrollment of children in Medicaid.				X
5. Provide leadership for the state Early Childhood Comprehensive Systems (ECCS) Project - access to health insurance is one of the five key areas of focus.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH and the CSHCN Program met with the President of the Oklahoma Chapter, American Academy of Pediatrics (OKAAP) to initiate discussion of collaboration on key issues pertaining to the health of Oklahoma children. Provision of health services to children eligible for Medicaid and support of the medical home concept were two of many topics discussed with agreement reached on the need to be visible in the state as collaborative partners in our efforts to improve the health of children.

In March, a Tulsa federal judge ruled that Oklahoma physicians who treat young Medicaid clients must be reimbursed the same amount of money as they would receive for treating senior citizens covered by Medicare. The judge ordered that reimbursement changes must occur in six months. The ruling came as a result of a lawsuit initiated in 2002 by the OKAAP. Low reimbursement rates have been cited as a reason that many physicians indicate an unwillingness to serve children eligible for Medicaid. Related, the OHCA is convening a state level work group this summer to explore immediate actions to be taken to improve the state's Medicaid services for children. The Chief of MCH is part of this work group that will focus initially on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Additional activities occurring to increase Medicaid coverage of children is the planning for implementation of the Premium Assistance Program and initiation of an option under Section 143 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248). The first phase of the Premium Assistance Program, being implemented under a Health Insurance Flexibility and Accountability (HIFA) Waiver, will allow persons who work for employers with less than 25 employees to become Medicaid eligible if household income is less than 185% of

federal poverty level (FPL). The client has to pay a portion of the insurance premium and the employer has to pay a portion of the insurance premium. Under the TEFRA option, disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parent's income or resources may now be eligible for services. This option allows children who are eligible for institutional services to be cared for in their homes. Only the child's income and resources are used in determining financial eligibility. The cost of care at home compared to the cost in an institutional setting is also used in determining eligibility. Children who meet eligibility requirements may be eligible for the full range of Medicaid covered services. Funds generated from the new tobacco tax that took effect on January 1, 2005 are to be used to support implementation of these Medicaid expansion projects.

The MCHB ECCS Planning Grant is in its second and final year. The state plan is near completion. The MCH ECCS Coordinator has been instrumental in assisting to guide the process of development of the state plan.

c. Plan for the Coming Year

October 1, 2005 is the target date for implementation of the Premium Assistance Program and the TEFRA option. MCH and the CSHCN Program will support the OHCA in its efforts to maintain this target date and will accomplish outreach and education to assure that health care providers and families are aware of these new opportunities for Medicaid health care coverage once available.

The Chief of MCH will continue to participate on the OICA Health Advisory Board as it continues to focus on outreach and assisting families to access Medicaid services and the OHCA work group as it focuses on improving Medicaid services to children.

County health department and contract provider staff will continue to assist families in the Medicaid process to enhance the success of families in applying for and accessing Medicaid. MCH and the CSHCN Program will provide technical assistance as the need is identified or requested and will assure that these staff are aware of the Premium Assistance Program and the TEFRA option as they become available.

The MCH School Health Program will collaborate with the State Department of Education on videoconferences that will address services for Medicaid eligible children. Technical assistance will be provided on linking children and their families to Medicaid. MCH staff will continue to provide information and resources on Medicaid to child care facilities and child care health consultants. Child care health consultants will also disseminate information on Medicaid to child care facilities and assist families with enrollment.

The state's ECCS plan will be implemented. The MCH ECCS Coordinator will continue to provide leadership and work with the OPSR as implementation occurs. The MCH ECCS Coordinator and MCH Family Advocate will assure that families continue to have the opportunity to provide input during implementation on all components to include access to health services.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.3	1.3	1.3	1.2	1.2
Numerator	643	665	642	600	600
Denominator	49530	49961	50289	50455	50455
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1

Notes - 2002

Vital statistics data were obtained from Health Care Information, Oklahoma State Department of Health. Data for year 2002 are considered provisional. Data for year 2001 have been revised to reflect final numbers.

Notes - 2003

PM#15: Data were obtained from Health Care Information, OSDH.

Notes - 2004

PM#15: Data were obtained from Health Care Information, OSDH. Year 2004 data are not yet available; therefore, year 2003 is repeated. Measure will be updated when new information becomes available.

a. Last Year's Accomplishments

The percent of infants born weighing less than 1,500 grams has remained unchanged in Oklahoma. Just over 1% of all Oklahoma resident births are born to this birth weight category. This is relatively consistent from year-to-year. For 2003, the latest year for which data are available, 600 newborns were delivered very low birth weight.

MCH continued to serve as a resource for the Healthy Start projects in Oklahoma and Tulsa counties. In April 2004, MCH co-sponsored a conference focused on prematurity with the Oklahoma County and Tulsa County Healthy Start projects and the Oklahoma Chapter of the March of Dimes. This conference brought together state and community leaders to discuss current strategies in preventing premature birth and decreasing very low and low birth weight infants.

Discussions were initiated with the Healthy Mothers/Healthy Babies Coalition to more formally identify its role as the state perinatal coalition and leadership it is to provide in enhancing health services for all pregnant women, mothers and infants.

The Tulsa Fetal and Infant Mortality Review (FIMR) Project evaluated its efficiency and effectiveness in carrying out FIMR activities with guidance from MCH. The Project found a need to restructure its case review process and to improve timeliness of presenting recommendations for systems changes to the Community Action Team. MCH increased funding to the project to assure capacity to accomplish its activities. Discussions on initiation of a FIMR Project in Oklahoma County continued with the Oklahoma City County Health Department.

Presumptive eligibility for Medicaid coverage of pregnant women seen through county health

departments and community clinics continued. MCH continued to provide prenatal and postpartum services for uninsured and underinsured women with 6,285 pregnant women provided maternity services during state fiscal year (SFY) 2004. The scope of maternity services varied from site to site ranging from one visit for risk assessment to full service clinics providing services through 40 weeks gestation. The scope of services reflected the demographic make-up of the community and availability of providers.

Education on the importance of adequate nutrition and healthy weight gain and its relationship to fetal growth and development was provided to pregnant women seen in maternity clinics. Pregnant women were linked to the Women, Infants and Children supplemental nutrition program (WIC).

Information on smoking and its impact on the health of the mother and unborn child continued to be provided to clients. Clients seen for family planning and maternity services, who were contemplating pregnancy and smoking or pregnant and smoking, were provided information on smoking cessation and referred to the Tobacco Helpline 1-800-quit-now.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Serve as a resource to state and community partners providing services to impact low birth weight.				X
2. Support and work with the state perinatal coalition, Healthy Mothers/Healthy Babies, to more formally identify its state leadership role in advocating/facilitating systems change to improve perinatal health.				X
3. Provide technical assistance and consultation to the Tulsa Fetal and Infant Mortality Review (FIMR) Project on FIMR process and to the Oklahoma City County Health Department as it initiates steps to implement a project for Oklahoma County.				X
4. Work closely with Medicaid to assure continuance of policy for presumptive eligibility for pregnant women.				X
5. Link pregnant women with the Women, Infants and Children supplemental nutrition program (WIC).		X		
6. Provide information on smoking and its impact on the health of the mother and unborn child - link women contemplating pregnancy and who smoke and pregnant women who smoke to smoking cessation services.		X		
7. Provide prenatal and postpartum care as a safety net provider through county health departments and contract providers.	X			
8. Educate pregnant women seen in county health department and contract maternity clinics on the importance of adequate nutrition and healthy weight gain and its relationship to fetal growth and development.	X			
9.				
10.				

b. Current Activities

Availability of, early entry into and receipt of ongoing routine prenatal care are priority focus areas for MCH. Across the state, reports are being received that physicians are discontinuing obstetrical services due to rising malpractice premiums. Rural hospitals are discontinuing deliveries as it is reported they cannot maintain standards of care related to timeliness in

having an anesthesiologist available in the event of an emergency delivery requiring a cesarean section. In addition, the continuing influx of the undocumented Hispanic population is placing a burden on the health system financially as well as with provider availability and capacity to assure culturally appropriate care.

MCH is working with the Coordinator of the Healthy Mothers/Healthy Babies Coalition to redefine the Coalition's structure and visibility in the state. The Healthy Mothers/Health Babies Coalition is currently conducting a survey of its members to target specific areas and activities for primary focus in education and advocacy efforts with the public and state and community-based policymakers this coming year.

The Chief of MCH is co-chairing a Perinatal Task Force with staff from the Oklahoma Health Care Authority (OHCA), the state Medicaid agency. This task force, initiated in May, is focused on improving the public system of perinatal care with a particular focus on the Medicaid system. It consists of public and private health care providers, consumers and policymakers who are working together to develop strategies to improve access to health care services, increase reimbursement rates to include high risk obstetrical care and provide more culturally appropriate care for clients with limited English proficiency (LEP). The task force is scheduled to meet every other month for the next year.

The Oklahoma State Department of Health (OSDH) is working closely with the Oklahoma Department of Human Services (OKDHS) and the Cabinet Secretary for Health to support the OHCA in its efforts to provide services to additional uninsured and underinsured pregnant women through the State Children's Health Insurance Program (SCHIP). This option would allow Medicaid to cover services for these pregnant women for the benefit of the health of the unborn child.

Centering Pregnancy, a model for delivering prenatal care in a group setting, is being piloted in the state. The Oklahoma Chapter of the March of Dimes awarded a grant to the Central Oklahoma Integrated Network Systems (COINS) to pilot the model in both urban and rural settings. MCH staff from the Women's Health Division serve as technical consultants to the project and pilot sites. Early indications are that the model is being well received by clients. Discussions have been initiated with the OHCA regarding reimbursement for services provided using this model.

c. Plan for the Coming Year

Information derived from the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system that provides health information on women who delivered a live birth in Oklahoma, will continue to be shared with policymakers and used by programs to promote needed systems changes.

The development and administration of a survey to gather information regarding the obstacles physicians and hospitals face in providing perinatal services will be completed by MCH. This information will be used in recommending and making health care systems and service changes for the state.

Collaborative work will continue with the Healthy Mothers/Healthy Babies Coalition to facilitate activities to address issues impacting the state's perinatal health care system. A top priority will be to look at issues involved in potentially restructuring the perinatal health care system into regions, particularly related to high-risk care and deliveries.

MCH will continue to participate in the Perinatal Task Force focused on improving the public health care system and Medicaid services. MCH will support the task force by providing needed data and other resources necessary for the group to move forward in its work.

MCH will continue to monitor activities regarding possible expansion of Medicaid to cover pregnant women under SCHIP. If this expansion occurs, this will allow MCH to realign funds to support enabling and population-based services needed by this population.

On November 1, Senate Bill 983 becomes effective. MCH worked with the OSDH Legislative Liaison on this legislation that will provide tort coverage for physicians and advanced practice nurses providing services to clients through county health departments. It is anticipated that this will assist in physicians and nurse practitioners being willing to contract with the OSDH to provide needed clinical services.

MCH will continue to serve as a resource to the state's Healthy Start projects. Collaboration will continue regarding provision of services, educational activities and training opportunities.

The Oklahoma County FIMR Project will be implemented. This first year will focus on establishing the process (e.g. developing relationships with hospitals, identifying case review team members, identifying community action team members, developing procedures). The FIMR Project in Tulsa County and MCH staff will provide technical assistance.

In areas of need, MCH will continue to provide prenatal and postpartum services. The model of providing prenatal care in a group setting will be evaluated for expansion to other clinical sites. Education on adequate nutrition and healthy weight gain and its impact on growth and development of the fetus will be provided to pregnant women and linkage of these women with WIC will occur. Women considering pregnancy who smoke and pregnant women who smoke will be provided information on smoking cessation and the Tobacco Helpline 1-800-quit-now.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9.7	9.5	9.2	9	9
Annual Indicator	8.7	9.5	10.2	11.4	11.4
Numerator	23	25	27	30	30
Denominator	264101	264101	264101	264101	264101
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.9	8.8	8.7	8.6	8.6

Notes - 2002

Vital statistics data were obtained from Health Care Information, Oklahoma State Department

of Health.

Notes - 2003

PM#16: Data were obtained from Health Care Information, OSDH.

Notes - 2004

PM#16: Data were obtained from Health Care Information, OSDH. Year 2004 data are not yet available; year 2003 is repeated to provide estimate for measure.

a. Last Year's Accomplishments

In 2003, the latest year for available mortality data, Oklahoma reported 30 self-inflicted deaths to teens aged 15 through 19. This results in a suicide death rate of 11.4 per 100,000 children in this age group. Recent years have witnessed an increase in the rate of suicide deaths. In 2000, the suicide rate was reported at 8.7 per 100,000 population. This represents an increase of 31% over this short time period. It should be noted that a small change in the number of events for this category of deaths can lead to fluctuation in the computed death rate. The five-year suicide death rate covering 1999-2003 was 9.9 deaths per 100,000 children aged 15-19.

Results of Oklahoma's first statewide-randomized Youth Risk Behavior Survey (YRBS) became available. Of particular note, the Oklahoma State Department of Health (OSDH), Board of Health (BOH) used the results of this survey as its area of focus for their annual State of the State's Interim Health Report. This report, which highlighted adolescent depression and suicide among other adolescent issues, was published and presented to members of the Oklahoma Legislature, school superintendents and the general public. A press conference with the BOH was held at the State Capitol in the fall of 2004. As a result of the report, increased awareness of the need to address youth suicide prevention continued to build in the state.

The MCH Adolescent Health Coordinator convened a statewide team to participate in a bi-regional training on suicide prevention hosted by the National Suicide Prevention Resource Center (SPRC). As a result of this conference, the team created the State Team on the Prevention of Suicide (STOPS). This entity is designed to compliment the work of the Oklahoma Youth Suicide Prevention Council by addressing suicide prevention across the lifespan.

The Oklahoma City Youth Suicide Prevention Coalition held the Third Annual Youth Listening Conference with Oklahoma City Public Schools and numerous community partners. This annual session provided youth an opportunity to present issues and proposed solutions to the leadership of the community (school board members, city council members, state legislators, business leaders and others).

The Oklahoma Youth Suicide Prevention Council held a series of train-the-trainer sessions around the state on the implementation of Youth Listening Conferences and Suicide Prevention Toolkit Trainings. The intent of these sessions was to provide communities with the tools to bring youth and adults together to mobilize the community around the issue of adolescent suicide and to begin a strategic planning process that would identify priorities for these communities to address.

Members of the Oklahoma Youth Suicide Prevention Council met with faculty of the University of Oklahoma College of Medicine to discuss strategies for training medical students and current professionals in suicide prevention and the recognition of at-risk clients and associated warning signs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. Disseminate Oklahoma Youth Risk Behavior Survey (YRBS) data to promote development of prevention activities.				X
2. Provide leadership for state training and policy setting activities.				X
3. Provide support and technical assistance for the Oklahoma Youth Suicide Prevention Council and its activities.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH facilitated the second statewide-randomized YRBS being accomplished this spring with results to be available in 2006. This will provide Oklahoma with data to compare with baseline data from the 2003 YRBS.

STOPS, in cooperation with the Oklahoma Youth Suicide Prevention Council, presented a statewide conference on suicide prevention in November 2004 at the University of Central Oklahoma. National speakers on youth suicide prevention presented information to state and community leaders. Primary goals of the conference were to establish state level networks analogous to the regional networks established by SPRC and to provide training in needs assessment, policy development and assurance of service in the arena of mental health. There were over 300 professionals, survivors and mental health consumers in attendance. Seven regional networks were established including one focusing on the Native American community.

The MCH Adolescent Health Coordinator has worked with the OSDH Injury Prevention Service to facilitate analysis of hospital discharge data and the sharing of this data with the Oklahoma Youth Suicide Prevention Council. This data provides a bridge between risk behavior data and death certificate data.

The Oklahoma Youth Suicide Prevention Council continues to provide community toolkit trainings for youth and adults. These trainings provide participants with active listening skills, an assessment of local resources and an analysis of current policy issues, particularly in regard to crisis response.

MCH continues to share data from the 2003 YRBS. Key among these are the indicators addressing depression and suicide ideation. Data from the YRBS are being included in a state youth suicide prevention federal grant application being submitted by the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS). The MCH Adolescent Health Coordinator has assisted in development of the grant that will provide further opportunities for MCH involvement with the DMHSAS in impacting health behaviors leading to suicide if funded.

c. Plan for the Coming Year

MCH will work with the Centers for Disease Control and Prevention (CDC) to finalize the data from the 2005 YRBS. This information will be compared to the baseline date obtained from the 2003 YRBS and results shared with the public as well as state and community leaders. Planning will take place, in partnership with the State Department of Education, to convene a

state level Youth Issues Conference in the fall of 2006 centered around the six risk taking behaviors addressed in the YRBS.

MCH will continue to support activities of the Oklahoma Youth Suicide Prevention Council. The MCH Adolescent Health Coordinator will remain actively involved in the activities of the Council.

The Youth Suicide Prevention Council will sponsor an Applied Suicide Intervention Skills Training (ASIST) on July 28-29, 2005. This is a gatekeeper training model that will involve school counselors, school resource officers, teachers and youth service workers. This training will provide skills necessary to identify at-risk youth and provide referrals to local mental health services.

The Oklahoma State Team on Suicide Prevention, created as a result of the 2003 Association of State and Territorial Health Officers (ASTHO)/SPRC Region VI Meeting, will hold the second annual state conference on suicide prevention on December 15-16, 2005. The conference will provide working sessions for the state regional suicide prevention teams and provide training in needs assessment, policy development and assurance of service in the arena of mental health.

The Oklahoma Youth Suicide Prevention Council will continue to provide community toolkit trainings for youth and adults. In addition, the council will participate in the Oklahoma Turning Point Council and the State Cooperative Agreement Advisory Council, a legislative council that advises state leaders on youth risk prevention activities and provides coordination for these prevention efforts.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	73.1	74.2	75.6	77.6	79.1
Annual Indicator	75.7	71.7	77.7	78.8	78.8
Numerator	487	477	488	473	473
Denominator	643	665	628	600	600
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80.3	81.5	82.7	84	85.2

Notes - 2002

Vital statistics data were obtained from Health Care Information, Oklahoma State Department of Health. Data for year 2002 are considered provisional. Data for year 2001 have been revised

to reflect final numbers.

Notes - 2003

PM#17: Data were obtained from Health Care Information, OSDH.

Notes - 2004

PM#17: Data were obtained from Health Care Information, OSDH. Data for year 2004 are not yet available. Year 2003 is repeated to provide estimate.

a. Last Year's Accomplishments

Referrals of high-risk clients from rural areas of the state were made to providers in Oklahoma City and Tulsa. Concerns regarding decreasing capacity to care for high-risk referrals began to be reported with the increasing influx of undocumented Hispanic clients. In Oklahoma for 2003, approximately 79% of newborns weighing less than 1,500 grams were delivered at high-risk facilities. This is a modest increase over previous years reporting. In 2000, about 76% of very low birth weight births occurred at high-risk facilities.

The Perinatal Continuing Education Program (PCEP), University of Oklahoma Health Sciences Center (OUHSC), continued to receive state funding through MCH to provide education and training to medical and nursing staff in rural hospitals. The PCEP provided rural hospital staff with knowledge and tools to better recognize and manage obstetrical and newborn emergencies that impact maternal and infant morbidity and mortality. The PCEP was active at 27 sites in state fiscal year 2004. Six hundred fourteen (614) perinatal health care providers participated in the PCEP, including 76 medical staff members (physicians, certified nurse midwives, physician assistants, and emergency medical personnel) and 538 nursing staff (registered nurses, licensed practical nurses, and respiratory therapists).

Two regional hospitals provided the PCEP under a subcontract with OUHSC: St. Mary's Regional Medical Center in Enid and Norman Regional Hospital. The third regional hospital, Comanche County Memorial in Lawton, had no hospitals in its region prepared to participate in the program during the state fiscal year. Workshops were provided by each of these hospitals to hospitals in their region. Topics included electronic fetal monitoring, gestational diabetes, ultrasonography, neonatal resuscitation, and neonatal resuscitation instructor training. In addition to formal workshops, the PCEP provided videotapes and teaching materials to perinatal staff that were unable to attend regional workshops and provided professional consultation to medical personnel across the state. The PCEP also published and distributed four editions of "Outreach", a newsletter that provided updates on current practice and information on changes in perinatal care.

MCH continued to provide technical assistance and serve as a resource to the Healthy Start projects in Oklahoma and Tulsa counties, the Children First Program and Office of Child Abuse Prevention family resource and support programs. These projects and programs provided in-home support to pregnant women and their families and facilitated pregnant women and their families being aware of signs and symptoms of pregnancy complications and where to seek prompt medical attention.

MCH continued to support the Oklahoma State Medical Association (OSMA) Maternal Mortality Review Committee in their limited activity during this period. MCH began exploring other state models for accomplishing maternal mortality review.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide support to the Perinatal Continuing Education Program (PCEP) to train hospital medical and nursing staff.				**X**
2. Serve as a resource and provide technical assistance to state partners providing services to pregnant women.				**X**
3. Provide support to the Oklahoma State Medical Association (OSMA) Maternal Mortality Committee. Explore how to restructure the process.				**X**
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Capacity for serving high-risk clients continues to decrease particularly in Tulsa. Both the University of Oklahoma (OU) and Oklahoma State University (OSU) clinics in Tulsa have limited the number of clients that could be accepted at various times during this year. Availability of providers and lack of translation services have been provided as reasons. Oklahoma City providers are also expressing concerns regarding provider availability and need for interpreters.

A related concern is the decreasing number of physicians that are providing obstetric services in the rural areas of the state. Women are finding the need to travel further for routine prenatal care and delivery and, if complications present, are experiencing difficulty with accessing needed services.

MCH is working closely with the Healthy Mothers/Healthy Babies Coalition, the Oklahoma Department of Human Services, the Oklahoma Health Care Authority (OHCA), physicians from the University of Oklahoma and Oklahoma State University, the Primary Care Association and the Oklahoma State Department of Health (OSDH) Office of Primary Care to develop strategies to improve the perinatal system of care. MCH is working with the Healthy Mothers/Healthy Babies Coalition to identify specific state level and community-based activities to impact the entire system (private and public) to include potential regionalization of services, particularly high-risk services. The Chief of MCH is co-chairing a task force with staff from the OHCA focused on improving the public system with a specific focus on Medicaid.

MCH has completed discussions within the OSDH and is ready to move forward this next year with discussions with the OSMA regarding restructuring of Oklahoma's maternal mortality review process. MCH is looking to centralize maternal mortality review in MCH with MCH staff to provide leadership to assure that cases are reviewed routinely from a multidisciplinary and systems approach and that recommendations are provided to appropriate MCH partners promptly for action.

c. Plan for the Coming Year

State funds were again line item appropriated for MCH to continue to fund the PCEP in state fiscal year 2006 to provide educational activities to medical and nursing staff in rural hospitals. In addition to the current courses provided by the PCEP, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Fetal Heart Monitoring Principles and Practices and the AWHONN Advanced Fetal Heart Monitoring Principles and Practices Workshops will be offered on an ongoing basis.

MCH will continue to serve as a resource to the Healthy Start projects, the Children First Program and Office of Child Abuse Prevention family resource and support programs. Staff from MCH Women's Health Division will continue to provide trainings and technical assistance to state level as well as local staff to assure safe and appropriate services are available.

MCH will continue to facilitate and participate in activities with its state level partners to identify and facilitate activities to improve the state's perinatal health care system. Availability of high-risk services and adequate reimbursement for high-risk services to include deliveries and care of newborns will be a specific area addressed in relation to the Medicaid system. MCH will work with the Healthy Mothers/Healthy Babies Coalition to educate and advocate with state and community-based leaders on critical issues to include the decreasing numbers of providers due to malpractice insurance costs as well as other barriers that physicians and hospitals face in providing these services.

Discussions will be initiated with the OSMA to restructure the maternal mortality review process. MCH will look to assure continued involvement by OSMA in the process while also assuring the process is accomplished from a multidisciplinary and systems approach. MCH plans to complete the restructuring by the end of the 2006 state fiscal year.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	82	82.5	83	83.5	83.5
Annual Indicator	78.7	77.5	76.8	77.8	77.8
Numerator	34089	37750	37537	38449	38449
Denominator	43313	48740	48908	49426	49426
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84.8	86	87.3	88.6	90

Notes - 2002

Vital statistics data were obtained from Health Care Information, Oklahoma State Department of Health.

Notes - 2003

PM#18: Data were obtained from Health Care Information, OSDH.

Notes - 2004

PM#18: Data were obtained from Health Care Information, OSDH. Year 2004 data are not

available. Data from previous year has been updated and repeated to provide an estimate.

a. Last Year's Accomplishments

Oklahoma vital statistics data for 2003 indicate that 78% of all births occur to women who receive timely prenatal care. The rate of first trimester entry into prenatal care has remained comparatively flat over recent years. Approximately 1 in 5 women did not receive prenatal care as early as they wanted.

The Oklahoma Areawide Services Information System (OASIS) continued as the Title V statewide 1-800 central toll-free telephone information/referral line with access to information also available through the OASIS website (http://oasis.ouhsc.edu). Women who contacted OASIS were provided information regarding available services in their area.

Maternity clinical services continued to be provided through county health departments and contract providers as needed in communities. These services ranged from providing the initial risk assessment, history, and physical and transitioning care to a local private physician early in the pregnancy to providing care throughout the pregnancy to time of delivery. Presumptive eligibility for Medicaid assisted in provision of these services. County health department and contract staff continued to assist women with completion of Medicaid applications to facilitate the approval process.

Outreach services continued to be supported through MCH contracts with Variety Health Center and Oklahoma City County Health Department in Oklahoma County and Tulsa City County Health Department in Tulsa County. Outreach workers, the majority bilingual, canvassed identified neighborhoods, conducted follow-up activities by phone, mail, and/or in person and facilitated enrollment in Medicaid.

MCH began to see a decrease in providers due to rising malpractice insurance costs. Reports also began to be received regarding hospitals who were discontinuing delivery services due to liability concerns. During MCH site visits to counties throughout the year, stories regarding issues with providers and hospitals were shared by local staff about how limited access to care was becoming more and more of a problem in many Oklahoma counties. One strategy MCH began to work on was to initiate discussions with the Oklahoma State Department of Health (OSDH) Community Health Services and the OSDH Legislative Liaison regarding updating of existing state statute to extend tort coverage to OSDH contract providers. Another strategy was to begin to engage the Healthy Mothers/Healthy Babies Coalition and Oklahoma Health Care Authority, the state Medicaid agency, in initial discussions regarding actions that might be taken to begin to impact these increasing concerns.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain support for the Title V statewide 1-800 central toll-free telephone information/referral line.				X
2. Partner with the state perinatal coalition, Healthy Mothers/Healthy Babies, and the state Medicaid agency, Oklahoma Health Care Authority, to educate state and community leaders on access issues impacting entry into first trimester care.				X
3. Collaborate with OSDH Legislative Liaison and Community Health Services to update existing state statute to provide tort coverage for OSDH contract providers (physicians, nurse practitioners and nurses).				X

4. Provide outreach services to facilitate women entering care in the first trimester.		X		
5. Link pregnant women with Medicaid through assisting in completion of Medicaid applications and connecting with providers who accept Medicaid.		X		
6. Provide prenatal services through county health departments and contract providers as a safety net provider.	X			
7.				
8.				
9.				
10.				

b. Current Activities

MCH has engaged in discussions throughout the year with the OSDH Commissioner of Health regarding the state's poor ranking nationally in relation to women entering prenatal care in the first trimester. MCH staff have analyzed and presented data to the Directors of the state's health and human services agencies. Information has been shared that Oklahoma medical providers historically having no consistent approach for defining entry into prenatal care. Concerns also shared with this group include the decreasing number of providers due to rising malpractice insurance premiums; closure of hospital delivery units due to concerns of liability issues related to inability to maintain expected standards of care for emergency deliveries; increasing influx of undocumented Hispanic clients; and, increasing unavailability of high-risk maternity services, particularly for women in rural areas of the state. These discussions contributed to the OSDH Commissioner of Health, the Director of the Oklahoma Department of Human Services and the Cabinet Secretary for Health writing a joint letter to the Oklahoma Legislature this year to gain their understanding of the issues faced by Oklahoma in meeting the health needs of this population.

Discussions occurred throughout the year regarding the possibility of expanding Medicaid to cover additional uninsured and underinsured women in need of prenatal services under the State Children's Health Insurance Program (SCHIP). Under this option, pregnant women could receive health services to benefit the health of the unborn child. Another activity has been the initiation of a Perinatal Task Force co-chaired by the Chief of MCH and OHCA staff to explore and identify strategies to improve perinatal services in the public health system with a particular focus on Medicaid.

The Chief of MCH has continued to work with the OSDH Legislative Liaison to facilitate changes in existing state statute regarding tort coverage of physicians and advanced practice nurses providing clinical services under contract with the OSDH.

MCH continues discussions with the Healthy Mothers/Healthy Babies Coalition and is assisting in increasing the visibility of the coalition and its activities to impact changes in the overall state perinatal health care system.

MCH has received three requests in the past six months to re-open previously closed maternity clinics (one in the western part of the state, one in the eastern part of the state and one in the southwest part of the state). MCH Women's Health staff are providing technical assistance to the sites and training staff to provide services according to program policy and procedures. These requests have come in relation to the need to provide services to the increasing undocumented Hispanic population.

c. Plan for the Coming Year

The OASIS will continue as the Title V statewide 1-800 central toll-free telephone information and referral service. It will continue to link women from across the state to their nearest prenatal care provider(s).

Collaborative activities will continue with the OHCA and the Healthy Mothers/Healthy Babies Coalition to identify and initiate changes to improve the perinatal health system. MCH will continue to participate in the Perinatal Task Force. MCH will support the task force by providing needed data and other resources necessary for the group to move forward in its work. MCH will continue to work with the Healthy Mothers/Healthy Babies Coalition to redefine the coalition's structure and visibility in the state. Support will be provided as the coalition educates and advocates with state and community leaders on the need to support health care systems changes.

MCH will continue to monitor activities regarding possible expansion of Medicaid to cover pregnant women under SCHIP. If this expansion takes place, this will allow MCH to realign funds currently spent on direct health services to support additional enabling and population-based services needed by this population.

On November 1, Senate Bill 983 becomes effective. This piece of legislation will provide tort coverage for physicians and advanced practice nurses providing services to clients through county health departments. It is anticipated that this will assist in physicians and nurse practitioners being willing to contract with the OSDH to provide needed clinical services.

MCH will complete the development and administration of a survey to gather additional information regarding the obstacles physicians and hospitals are facing in providing perinatal health care services. Information from this survey will be used in facilitating health care systems and services changes for the state.

MCH will explore expanding the Centering Pregnancy model as a means for increasing access to and early entry into prenatal care. This model provides group prenatal care to pregnant women and is designed to promote healthy pregnancy outcomes. The sites currently piloting the model include a county health department and four other health centers in the state. The pilots are being funded through an Oklahoma Chapter of the March of Dimes grant to the Central Oklahoma Integrated Network System (COINS). MCH Women's Health staff serve as technical consultants to the project and pilot sites.

Maternity services will continue to be provided through county health departments and contract clinics based on community need. MCH will provide technical assistance to county health departments and contract providers as they continue to educate communities on issues that impact entry into first trimester prenatal care such as pregnancy planning, preconception care and the importance of early and routine prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	45.0	44.0	43.0	42.0	41.5
Annual Indicator	46.9	52.1	48.5	48.4	48.4
Numerator	23300	26064	24400	24623	24623
Denominator	49680	50027	50310	50874	50874
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40.9	40.3	39.5	38.7	37.9

Notes - 2002

SPM#1: Data were obtained from Oklahoma PRAMS.

Notes - 2003

SPM#1: Data were obtained from Oklahoma PRAMS.

Notes - 2004

SPM#1: Data were obtained from Oklahoma PRAMS. Year 2004 data are not available. Year 2003 data repeated as an estimate for 2004.

a. Last Year's Accomplishments

MCH continued to monitor unintended pregnancy through data from the Centers for Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system that provides health information on women who delivered a live birth in Oklahoma. PRAMS data for year 2003, the most recent available, reveal that 48.4% of all Oklahoma live births are the result of an unintended pregnancy. Despite some fluctuation in recent years, this finding is comparatively consistent in that nearly half of Oklahoma births are the outcome of either a mistimed or unwanted pregnancy.

The Oklahoma Areawide Services Information System (OASIS) continued as the Title V statewide 1-800 central toll-free telephone information/referral line with access to information also available through the OASIS website (http://oasis.ouhsc.edu). Women who contacted OASIS were provided information regarding available family planning services in their area.

MCH worked closely with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, and the Oklahoma Department of Human Services (OKDHS) to facilitate approval of the Medicaid family planning waiver, an expansion of family planning services up to 185% of federal poverty level for women and men 19 years of age and older. MCH also engaged in discussions with the Title X Region VI Family Planning Office to clarify integration of policy and procedure and use of existing state funds as match for the waiver. The Title X Region VI Family Planning Office provided reassurance of their support for the waiver and the use of existing state funds historically used for Title X family planning services as state match for Medicaid services to be provided through the waiver.

Numerous staff development opportunities were provided with topics selected based on federal Title X program priorities/key issues as well as an annual needs assessment accomplished by MCH of county health department and contract agency staff providing family planning services. For a second year, the University of Texas, Southwestern Medical Center at Dallas provided onsite training for clinicians providing reproductive health services through county health departments and contract providers. Online courses were also part of this training and provided

up to 48 hours of continuing education units. This training was made possible through a Title X training grant.

Comprehensive family planning services were provided through county health departments and contract clinics. Services included comprehensive histories and physical exams, laboratory services, methods education and counseling, provision of contraceptive methods, sexually transmitted disease (STD)/Human Immunodeficiency Virus (HIV) screening and prevention education, pregnancy testing, immunizations, smoking cessation and education on nutrition and exercise. Services were provided to 79,863 clients in calendar year 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor unintended pregnancy through the Pregnancy Risk Assessment Monitoring System (PRAMS).				X
2. Maintain support for the Title V statewide 1-800 central toll-free telephone information/referral line - provides client linkage with family planning services in community.				X
3. Collaborate with the state medicaid agency, Oklahoma Health Care Authority, and the Oklahoma Department of Human Services to facilitate activities to gain approval and implement a state family planning waiver.				X
4. Provide training and education activities to assure staff ability to provide high quality family planning services.				X
5. Provide comprehensive family planning services through county health departments and contract clinics.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In November 2004, Oklahoma received a written letter of approval for implementation of the Oklahoma Medicaid Family Planning Waiver, SoonerPlan, from the Centers for Medicare and Medicaid Services (CMS). Multiple weekly meetings immediately began with staff from the OHCA, OKDHS and OSDH, to include MCH, collaborating over the next several months to finalize plans for implementation. On April 1, 2005, SoonerPlan was implemented statewide. SoonerPlan enhances the state's ability to provide statewide family planning services through public and private providers. These services target females and males 19 years of age and older with incomes at or below 185% of federal poverty level (FPL). Regional trainings involving state office staff from the OHCA, OKDHS, OSDH and MCH were provided to county health department and contract staff during the months of March and April to facilitate implementation of the waiver. County health departments and contracting agencies are playing a key role in providing information, assisting with completion of the Medicaid application and providing clinical family planning services to females and males. Currently an average of 750 applications a week are being submitted to the OKDHS for determination of eligibility for this new Medicaid service.

Monthly coordination meetings involving staff from the OHCA, OKDHS, OSDH and MCH

continue to take place since implementation of the waiver to assure ongoing communications and continuity in administration of the waiver. MCH staff have a significant role in these meetings due to MCH's responsibility organizationally within the OSDH to set program policy and procedure for delivery of family planning services through the OSDH's statewide public health system. MCH staff provide technical assistance and consultation onsite as well as by telephone and e-mail to staff as these services are integrated into the existing service system.

In February 2005, MCH in partnership with the University of Texas Southwestern Medical Center, sponsored for the third year the Oklahoma Family Planning Conference. This training focused on current trends in women's health care and was attended by advanced practice nurses and registered nurses from county health departments and contract agencies.

Of ongoing concern is the ability to hire and retain health care providers for provision of clinical services. Two steps have been taken this year to address this concern. First is the passage of legislation that will provide tort coverage for physicians and advanced nurse practitioners providing OSDH services. It is anticipated that this will assist the OSDH in acquiring the needed services of these health care providers, as it will assist with liability concerns that have been raised. The second is a recent adjustment in salary of advanced nurse practitioners employed by the OSDH.

c. Plan for the Coming Year

Reduction of unwanted, unplanned pregnancies continues to be a state priority as identified through the state needs assessment. This state performance measure will be continued.

The PRAMS will continue to be used by MCH to monitor unintended pregnancy. Information will be used to educate providers, policymakers, perinatal coalitions, communities and the public as well as monitor health outcomes and provide support for policy and health care systems changes.

The OASIS will continue as the Title V statewide 1-800 central toll-free telephone information and referral service. It will continue to link women from across the state to their nearest family planning provider(s).

Coordination will continue with the OHCA and OKDHS to assure continuity in administration of services provide through the family planning waiver. MCH will continue to provide technical assistance and consultation to county health department and contract agency staff as issues arise around provision of these services.

Staff development activities will be offered through conferences, onsite trainings and team station broadcasts. Training topics will focus on federal and state priorities.

Comprehensive family planning services will be provided through county health departments and contract clinics. Services will include comprehensive histories and physical exams, laboratory services, methods education and counseling, provision of contraceptive methods, STD/HIV screening and prevention education, pregnancy testing, immunizations, smoking cessation and education on nutrition and exercise.

State Performance Measure 2: *The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			70	75	130
Annual Indicator			67	127	120
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	134	138	142	146	151

Notes - 2002

Due to the budget issues that the State of Oklahoma is experiencing the amount of money available for respite care has remained constant and there has been no reduction in cost. Therefore, the same information has been reported for the past three report periods. This performance measure has been modified at the suggestion of the past reviewers. The data previously reported was based on the increase in the number of days of respite care over the previous year. Now the performance measure reports the number of families that are assisted with respite care.

Notes - 2003

SPM#2: Data were obtained from the Oklahoma Department of Human Services. The increase in the number reported on this PM reflect the first time that CSHCN was able to capture data on respite care paid by Developmental Disabilities Services Division, OKDHS.

Notes - 2004

SPM#2: Data were obtained from the Oklahoma Department of Human Services.

a. Last Year's Accomplishments

The CSHCN Program continued to take an active role in the Oklahoma Respite Resource Network (ORRN), which continued to expand respite care in the state. The Oklahoma Areawide Services Information System (OASIS), the Title V toll-free information and referral line, continued to complete the initial processing on all respite care applications for the state. After the initial screening, the applications were routed to the appropriate funding source, either the Developmental Disabilities Services Division (DDSD) or the CSHCN Program. Having a central referral point enabled more individuals and families to be served. The CSHCN Program processed 120 referrals for respite care.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Participate in the Oklahoma Respite Resource Network activities.				**X**
2. Provide information and linkage of families to respite care.		**X**		

3. Provide respite care services.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The J.D. McCarty Center completed their move to a new and much larger facility thus increasing the number of individuals they can accept for respite care. This facility, which provides respite care for medically fragile individuals, is the only one of its kind in the state. The increase in the number of individuals they can serve will relieve the waiting list that normally exists for respite care.

Collaboration is occurring with the ORRN as planning is completed for a national respite conference. This conference will be hosted in Oklahoma City in September 2005.

c. Plan for the Coming Year

The need for respite care services continues to be a state priority as identified through the state needs assessment. This state performance measure will be continued.

The CSHCN Program will continue funding the OASIS and support its role in receiving and screening all applications for respite care. After the initial screening, the OASIS will route the referral to either the CSHCN Program or the DDSD, whichever is appropriate. This system also allows the OASIS to search for other funding sources if funds are exhausted in either the CSHCN Program or the DDSD. The CSHCN Program will continue to work with the ORRN to increase funding and availability of respite care in the state.

State Performance Measure 3: *The rate of neural tube defects among live births in Oklahoma (rate per 10,000 live births).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.5	6.0	5.5	5.0	4.9
Annual Indicator	5.0	4.6	4.8	4.5	2.9
Numerator	25	23	24	23	14
Denominator	49680	50027	50310	50874	47782
Is the Data Provisional or				Provisional	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.4	4.4	4.3	4.3	4.3

Notes - 2002

Data were provided by Screening and Special Services, Oklahoma State Department of Health. Data for year 2002 are provisional.

Notes - 2003

SPM#3: Data were obtained from the Oklahoma Birth Defects Registry, Screening and Special Services, OSDH. Data are considered provisional.

Notes - 2004

SPM#3: Data were obtained from the Oklahoma Birth Defects Registry, Screening and Special Services, OSDH. Data are considered provisional.

a. Last Year's Accomplishments

The Oklahoma Birth Defects Registry (OBDR), a statewide population-based active surveillance system of children born with birth defects in Oklahoma, continued to be funded with Title V MCH funds. Provisional data from the OBDR indicate a decrease in the live birth rate of anencephaly and spina bifida from 4.52/10,000 live births in 2003 to 2.93/10,000 live births in 2004.

The Centers for Disease Control and Prevention (CDC) cooperative agreement, Oklahoma Birth Defects Registry Improvement Project, provided funding to pilot a preconception care project at Tulsa City County Health Department. The project consisted of women's health appraisals to identify risk factors and accompanying educational pamphlets. Folic acid for the prevention of neural tube defects (NTDs) was a major component of the project. Multivitamins were purchased for clients receiving preconception education. Preliminary analysis of pre and post evaluation forms completed by women participating in the pilot, identified a marked increase in multivitamin use. In July 2004, the pilot was expanded to two additional county health departments, Logan and Pottawatomie.

The Oklahoma Coalition on Folic Acid distributed over 120,000 folic acid educational materials and specialty items to county health departments, pharmacies, public schools and physician offices requesting materials. Separate materials were available for two distinct categories: women contemplating pregnancy and non-contemplators. Materials sent to county health departments were utilized by the following Oklahoma State Department of Health (OSDH) programs: family planning, Women, Infants and Children supplemental nutrition program (WIC), Children First, Office of Child Abuse Prevention family resource and support programs, and in addition, the Healthy Start projects in Oklahoma and Tulsa counties.

Through a grant from the March of Dimes Birth Defects Foundation, tabletop display boards were purchased for placement in county health departments with the highest prevalence of NTDs. A tabletop educational display, titled Folic Acid -- For Health Now and In the Future, was developed and sent to twelve county health departments for placement in a prominent location within each facility. Multivitamins were provided to all twelve county health departments for distribution to women of childbearing age. A news release was also developed for those counties wanting to open vitamin distribution to the general public.

In April 2004, the OBDR Coordinator was asked to present on Oklahoma's birth defects registry and folic acid prevention efforts at the National Council on State Legislators in Washington D.C. The activity helped educate policymakers from across the United States regarding the importance of birth defects registries in folic acid and NTD prevention efforts.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and evaluate pilot preconception care project.				X
2. Provide ongoing statewide birth defects surveillance and use data to identify impact of interventions/areas for concern.			X	
3. Collaborate with state partners to use folic acid prevention education materials.			X	
4. Provide additional education materials and vitamins to women of childbearing age seen through county health departments in counties with the highest prevalence of neural tube defects.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The data for this measure indicate a continuing improvement and the state needs assessment did not document this as one of the top 10 state priority focus areas. MCH, acknowledging the importance of maintaining the OBDR and its related population-based prevention activities, currently plans to continue to make available Title V MCH funds to support these important activities.

Linkage of MCH data to OBDR data is to be accomplished through activities of the State Systems Development Initiative (SSDI), a Maternal and Child Health Bureau (MCHB) funded project focused on linking of data systems to gain a more comprehensive picture of the health of the maternal and child health populations.

Early detection of spina bifida and anencephaly will continue through tertiary hospitals in Oklahoma City and Tulsa. The mothers of these babies will be sent letters and educational information regarding their increased risk for NTDs in subsequent pregnancies. The OBDR will continue to provide data to the CDC each quarter as a part of the National Birth Defects Prevention Network (NBDPN) NTD Ascertainment Project. Oklahoma is one of twenty-six states participating in this quarterly NTD trend study.

Population-based prevention activities to include statewide educational campaigns and training support and materials will continue to be provided. Technical assistance and consultation will continue to be available to public and private providers on folic acid to include its critical role in the prevention of NTDs and appropriate use.

c. Plan for the Coming Year

This state performance measure has been discontinued.

State Performance Measure 4: *The proportion of women who achieve the recommended*

weight gain during pregnancy

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	35.0	37.0	39.0	41.0	41.2
Annual Indicator	38.7	34.7	35.3	37.7	37.7
Numerator	19226	17359	17759	19179	19179
Denominator	49680	50027	50310	50874	50874
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	42	42.9	43.7	44.6	45.5

Notes - 2002

Data were provided by the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data reported for FY2001 and FY2002 are not yet available; therefore, the estimate for FY2000 has been applied to birth data for those years.

Notes - 2003

SPM#4: Data were obtained from Oklahoma PRAMS, MCH Assessment.

Notes - 2004

SPM#4: Data were obtained from Oklahoma PRAMS, MCH Assessment. Data for year 2004 are not available; year 2003 data are repeated to provide an estimate for this measure.

a. Last Year's Accomplishments

PRAMS data for year 2003, the most recent available, indicate that 37.7% of pregnant women gain the recommended amount of weight during their pregnancies. Recent data from PRAMS over the last decade reveals a decline in the percent of mothers who fall within the recommended guidelines for the weight gain during pregnancy. In 1995, 41% of mothers responding to the PRAMS survey reported gaining the recommended pregnancy weight.

The logistics of linking MCH data with other health data systems continued to be a key focus of MCH. Linking of data is expected to provided MCH and other programs with more comprehensive information of health issues such as nutrition and weight. Discussions continued with other Oklahoma State Department of Health (OSDH) programs and the state Medicaid agency with many issues related to access and confidentiality worked out. These accomplishments were part of activities of the State Systems Development Initiative (SSDI), a Maternal and Child Health Bureau (MCHB) funded project focused on the Title V Block Grant ongoing needs assessment, performance and outcome measures and the Health System Capacity Indicators (HSCI), specifically HSCI #9 which relates to linking of data systems.

Healthy weight gain during pregnancy and healthy lifestyle choices during the preconception period continued to be promoted by MCH. The importance of normal body mass index (BMI) at the time of conception was discussed with women seen in family planning clinics who were

considering pregnancy. Pregnant women seen in maternity clinics received education on nutrition needs and appropriate weight gain during pregnancy and were linked to the Women, Infants and Children supplemental nutrition program (WIC), Children First and/or local family resource and support programs for continued support.

Collaborative work occurred with WIC, Children First, local family resource and support programs and the Healthy Start projects. Pregnant women served by these programs and projects had an initial nutrition and weight history obtained and a baseline weight recorded. Nutrition and weight were monitored throughout the pregnancy to assure weight gain was adequate with any concerns referred to the woman's primary health care provider.

Efforts continued to obtain a nutritionist for the MCH state office to work with MCH programs for the enhancement of nutrition services, provision of technical consultation and to serve as a resource to county health departments and contract providers.

Responsibilities of a health educator position in MCH Women's Health Division were redefined to focus at least half of its time on preventive health activities with nutrition being a priority. Expectations for this position are to work closely with the MCH Nutritionist on education and training activities, identification and development of nutrition resources for use by providers and provision of technical assistance and consultation.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate continued activities to accomplish linking of data between the Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children supplemental nutrition program (WIC), vital statistics and Medicaid.				X
2. Collaborate and serve as a resource to state partners providing prenatal services.				X
3. Link pregnant women seen in county health department and contract provider maternity clinics with WIC as well as other OSDH programs providing needed health and support services.		X		
4. Provide nutrition services to family planning and maternity clients seen through county health department and contract provider clinics.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the state needs assessment process, the decision was made to discontinue this state performance measure and to replace it with a new state performance measure focused more specifically on the identified priority of reducing the prevalence of obesity among the MCH populations. During the needs assessment process, it was noted that activities for this state performance measure are activities also found in addressing National Performance Measure #11 Percentage of mothers who breastfeed their infants at hospital discharge and National

Performance Measure #15 The percent of very low birth weight infants among all live births. Activities accomplished for these two measures will assure ongoing attention to this issue.

Plans are to link MCH data to data from other OSDH programs and the state Medicaid agency through activities of the State Systems Development Initiative (SSDI), a Maternal and Child Health Bureau (MCHB) funded project focused on linking of data systems to gain a more comprehensive picture of the health of the maternal and child health populations. Linkage will provide information to assist with providing and developing more targeted nutrition services.

MCH plans to assure women seen through county health department and contract provider family planning clinics and maternity clinics continue to receive information on the importance of adequate nutrition and appropriate weight. MCH also plans to continue to provide technical assistance and training as requested to assure appropriate services are provided.

In December 2004, a MCH Nutritionist was hired. This individual brings over 20 years of experience providing public health nutrition services in a variety of settings to include the state Women, Infants and Children's supplemental nutrition program (WIC). Since joining MCH, this staff has linked with MCH programs and is providing technical assistance and consultation in strengthening and developing nutrition services as part of the overall services provided through the Child and Adolescent Health Division and Women's Health Division as well as surveillance activities accomplished through MCH Assessment. Having this critical piece of infrastructure back in place is allowing MCH to provide leadership at the state level to impact the nutritional status of the maternal and child health populations.

The Health Educator position in Women's Health began work on June 20, 2005. This staff is becoming acquainted with the responsibilities of this position and being integrated into activities of the Division. Plans remain in place for this staff to work closely with the MCH Nutritionist on population-based prevention activities.

c. Plan for the Coming Year

This state performance measure has been discontinued.

State Performance Measure 5: *The percent of adolescents grades 9-12 smoking tobacco products*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	31.8	31.6	31.3	28.2	24.8
Annual Indicator	33.5	33.5	24.0	26.5	26.5
Numerator	90240	90240	62671	69200	69200
Denominator	269373	269373	261131	261131	261131
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	24.4	23.9	23.6	23.2	22.8

Notes - 2002

Data were obtained from the Youth Risk Behavior Survey, MCH Assessment. YRBS data are not a statewide sample but aggregate data collected for Oklahoma schools that choose to participate in the survey.

Notes - 2003

SPM#5: Data were obtained from Oklahoma statewide YRBS 2003.

Notes - 2004

SPM#5: Data were obtained from Oklahoma statewide YRBS 2003. Data for year 2004 are not available; year 2003 is repeated.

a. Last Year's Accomplishments

According to data from the 2003 Oklahoma statewide-randomized Youth Risk Behavior Survey (YRBS), 27% of students used cigarettes in the past month. Males demonstrated a higher usage with 28.5% having used cigarettes, compared with 24.3% of females. Year 2003 marked the first year in which the statewide YRBS was conducted in Oklahoma. Prior reporting for this measure was the result of aggregated YRBS data. As a consequence, it is improper to discuss trend data, which may misrepresent or inadequately reflect adolescent smoking behavior. Future statewide YRBS data collection is planned to provide an ongoing tracking mechanism.

MCH, the Oklahoma State Department of Health (OSDH) Tobacco Use Prevention Service, the State Department of Education (SDE) and the Department of Mental Health and Substance Abuse Services (DMHSAS) met and agreed to coordinate survey administration to decrease the impact on schools and thereby enhance the continued successful administration of each of their surveys. A letter of agreement between the OSDH, SDE and the DMHSAS was signed in 2004.

With MCH and Tobacco Use Prevention Service identifying the need to survey on the same years, a plan for coordination of the administration of the Oklahoma Youth Tobacco Survey (OYTS) and Youth Risk Behavior Survey was developed. A joint sample to coordinate the surveys was pulled for the administration of both surveys in the spring of 2005.

Collaboration continued with the Tobacco Use Prevention Service and the Dental Service on youth tobacco use prevention activities across the state. Strategies to reduce tobacco use included community-based initiatives, classroom programs, counter marketing campaigns and youth cessation programs. The focus continued to be on elementary and middle school students.

The OSDH and the OSDE began to fund the infrastructure of the Schools for Healthy Lifestyles Program during state fiscal year 2004 when the Maternal and Child Health Bureau (MCHB) Healthy Tomorrow Grant ended. The program continued in three school districts in 23 elementary schools. One of the four program focus areas was tobacco use prevention. MCH was given the responsibility of oversight of the administration of the funds from the OSDH to the Schools for Healthy Lifestyles Program. MCH staff continued to be the primary source for technical assistance to the Schools for Healthy Lifestyles Program participating in the summer training institute for schools and being available to program staff throughout the year.

State tobacco settlement dollars continued to fund 14 rural district school nurses in the state. The nurses focused 50% of their time on tobacco prevention activities. The MCH School Health Program provided technical assistance to the nurses, as well as to other school nurses and

personnel statewide on tobacco use prevention. Information continued to be shared via video conferencing, monthly resource packets, a school nurse listserv and the quarterly School Health Newsletter.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate Oklahoma Youth Risk Behavior Survey (YRBS) data to promote development of prevention activities.				X
2. Collaborate with OSDH Dental Service and Tobacco Use Prevention Service on prevention activities for schools and communities.				X
3. Provide support and technical assistance for the Schools for Healthy Lifestyles Program.				X
4. Provide technical assistance to school nurses and personnel on tobacco use prevention activities.				X
5.				
6.				
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10.				

b. Current Activities

MCH, in collaboration with the SDE and the Centers for Disease Control and Prevention (CDC), completed the second statewide-randomized Youth Risk Behavior Survey (YRBS) for Oklahoma in the spring of 2005. Tobacco use was among the risk behaviors measured.

The OSDH and SDE continue to support the Schools for Healthy Lifestyles Program. The Schools for Healthy Lifestyles Program is implementing a new strategy in an effort to expand the program across the state. The program will "roll off" schools as they attain certified Schools For Health Lifestyles status after three years of successful participation in the program. Eight schools were "rolled off" at the end of the 2004-2005 school year.

Tobacco use prevention curriculum has been purchased by MCH for use in this summer's training institute for schools participating in the Schools for Healthy Lifestyles Program. A team of three staff from each school is required to participate. MCH staff from the Child and Adolescent Health Division serve on the planning committee and assist with provision of the training.

A Memorandum of Agreement has been signed by the OSDH and the SDE designating the MCH School Health Program with the authority to develop state policy and procedure for school health services and to be the technical consultant for school health nurses working in public schools statewide. MCH is working closely with staff from the SDE to assure consistency with state education policies. This role with school nurses will provide MCH with the opportunity to provide strategies and tools directly to school nurses in their efforts to reduce tobacco use.

c. Plan for the Coming Year

Reducing substance abuse behaviors in the MCH populations was identified as one of the top

10 state priorities through the state needs assessment. Tobacco use prevention is a priority of the OSDH and the OSDH Board of Health. This state performance measure will be continued.

Data from the 2005 YRBS will be received and compared to the baseline data from the 2003 YRBS. The resulting information regarding tobacco use will be shared with the public, health care providers, programs focused on tobacco use prevention as well as state and community policymakers. MCH, with state partners, will also use this information to explore and identify new strategies to further reduce youth tobacco usage.

Collaboration will continue with the Tobacco Use Prevention Service and the Dental Service on youth tobacco use prevention activities across the state. Activities to reduce tobacco use will focus on prevention programs through school settings targeting elementary and middle school students.

The Schools for Health Lifestyles Program will continue to be supported with funds from the OSDH and SDE. MCH will continue to be responsible for oversight of the program. Technical assistance will continue to be provided as the program expands to nine different school districts and a total of 29 elementary schools. The program will continue to "roll off" schools as they attain certified Schools For Health Lifestyles status after three years of successful participation in the program.

State Performance Measure 6: *Number of communities with a Turning Point initiative that addresses the needs of their MCH populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	5	7	9	50	55
Annual Indicator	6	15	43	48	54
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57	59	61	63	66

Notes - 2002

Data provided by OSDH, Community Health Services, Community Development Service.

Notes - 2003

SPM#6: Data provided by OSDH, Community Health Services, Community Development Service.

Notes - 2004

SPM#6: Data provided by OSDH, Community Health Services, Community Development Service.

a. Last Year's Accomplishments

MCH provided infrastructure support to Turning Point through funding of regional staff who worked to support and develop local Turning Point partnerships. In 2004, Turning Point reported that 54 communities had initiatives that concentrate on the health needs for MCH populations. This represents a modest increase over the previous year's reporting.

MCH continued to participate in meetings of the state Turning Point Advisory Council and subcommittees as they focused on activities to improve the health care and public health infrastructure in the state. MCH collaborated with local Turning Point partnerships to facilitate activities designed to improve systems of care for the MCH population.

One of the newest partnerships developed during 2004 was the Oklahoma County Turning Point Partnership, which encompasses the state's largest urban area population. The partnership completed the assessment phase and began meetings to plan implementation of the identified priorities, many of which were related to the MCH population.

As new partnerships developed across the state, they conducted needs assessments, a resource assessment and prioritized problems and needs. As partnerships conducted these assessments and prioritized focus areas, women, children and youth issues were often found at the top of priorities to be addressed. Examples included: access to health care for uninsured and underinsured children and mothers; adolescent health; immunizations; child safety seat usage and proper installation; children's mental health issues; family involvement at school; teen pregnancy prevention; healthy lifestyles promotion for families; parent resource center for early childhood development; walking trails, bike trails and the importance of physical activity for children and adults; and, youth tobacco use prevention.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance and support to community Turning Point partnerships.				X
2. Participate in state level turning Point Advisory Council, subcommittees and work groups.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the state needs assessment process this year, and as a result of MCH comprehensive site visits to county health departments and contract providers the past two years, Turning Point partnerships have been identified as a means/strategy for addressing MCH state priorities. During this year, MCH realigned and prioritized use of Title V funds to provide

additional support of regional Turning Point staff to strengthen the infrastructure of this key resource to MCH. MCH will work with the Turning Point Program within the Oklahoma State Department of Health (OSDH) Community Health Services, the state Turning Point Council and local Turning Point partnerships as a strategy to impact the identified MCH state priorities.

During MCH comprehensive site visits to county health departments and contract providers, MCH will assure linkage of MCH providers with their local Turning Point partnership or assist them in initiating the development of a local partnership if one does not exist. Local partnerships have been found to be broadly representative of the community, conduct or facilitate strategic planning based on assessment of needs and utilize diverse interventions in addressing the specific priority areas identified.

There are currently 55 Turning Point partnerships. Six Turning Point field consultants provide support to these local partnerships. MCH will use information received and seek input from Turning Point to use in program development and continue to provide technical assistance to Turning Point as the need arises.

c. Plan for the Coming Year

This state performance measure has been discontinued.

State Performance Measure 7: *The prevalence of partner violence in adolescent relationships.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.0	16.0	15.0	14.0	9.4
Annual Indicator	10.0	10.0	7.6	9.5	9.5
Numerator	26119	26119	19851	24807	24807
Denominator	261191	261191	261131	261131	261131
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.3	9.1	9	8.8	8.7

Notes - 2002

Data were obtained from the Youth Risk Behavior Survey, MCH Assessment.

Notes - 2003

SPM#7: Data were obtained from the Oklahoma Youth Risk Behavior Survey, statewide 2003.

Notes - 2004

SPM#7: Data were obtained from the Oklahoma Youth Risk Behavior Survey, statewide 2003. Data for year 2004 are not available.

a. Last Year's Accomplishments

State data from the first statewide-randomized Youth Risk Behavior Survey (YRBS) completed in the spring of 2003 became available. Violence was among the areas measured in the survey. When asked if a boyfriend or girlfriend had ever physically hurt them on purpose, both males and females were slightly higher than the national average at 9.5% combined. Looking at forced sexual intercourse, 12% of females and 4.5% of males reported being forced. This is slightly lower than the national total reported of 11.9 and 6.1 for females and males respectively.

Teen pregnancy prevention projects addressed sexual assault and sexual coercion as part of their classroom curriculum and as part of their parent education program. The Oklahoma Family Planning Program, administered through MCH, prioritized educating staff and clients on sexual coercion and prevention strategies. The MCH School Health Program provided information on prevention of youth violence through the School Health Newsletter and communications with school nurses. MCH collaborated with the Oklahoma State Department of Health (OSDH) Injury Prevention Service and Department of Mental Health and Substance Abuse Services providing consultation and technical assistance as planning of services for this population occurred.

The Adolescent Health Coordinator remained actively involved with the Oklahoma Youth Suicide Prevention Council. This council continued to focus on violence as a risk factor for depression and suicide ideation. During its annual youth listening conference, youth were provided the opportunity to express concerns about youth violence to policymakers and city and school officials.

Local Turning Point partnerships worked within their communities to provide education to parents, youth and school personnel on youth violence. Technical assistance and information was provided by MCH as requested.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate Oklahoma Youth Risk Behavior Survey (YRBS) data to promote development of prevention activities.				X
2. Collaborate with local Turning Point partnerships on community and parent education.				X
3. Provide technical assistance and consultation to the Oklahoma City Youth Suicide Prevention Coalition in its training/education activities.				X
4. Provide education to youth and their parents on intimate partner violence through Teen Pregnancy Prevention Projects' activities.			X	
5. Educate clients seen through county health department and contract provider family planning clinics on sexual coercion and prevention strategies.	X			
6.				
7.				
8.				
9.				

10.				

b. Current Activities

Partner violence in adolescent relationships was not identified as one of the top ten priorities from the state needs assessment. The decision has been made at this time to discontinue this state performance measure. During the state needs assessment process, it was identified that the OSDH Injury Prevention Service, Department of Mental Health and Substance Abuse Services, Office of Juvenile Affairs as well as several local Turning Point partnerships have prevention of youth violence as a priority. MCH plans to work collaboratively with these state level partners and local Turning Point partnerships to support their efforts. MCH also plans to continue current efforts already integrated into the teen pregnancy prevention projects, the Oklahoma Family Planning Program and the School Health Program. These efforts will focus on building and strengthening youth assets, prevention of bullying, educating youth on how to say "no", developing healthy relationships and recognizing unhealthy relationships.

Data from the 2005 YRBS will be received and compared to the baseline data from the 2003 YRBS. MCH will share data and comparison findings with the Injury Prevention Service, other state agencies and local Turning Point partnerships focused on preventing youth violence.

c. Plan for the Coming Year

This state performance measure has been discontinued.

State Performance Measure 8: *The percent of mothers who smoke during the third trimester of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective			15	14	20.1
Annual Indicator			20.0	16.2	16.2
Numerator			10062	8242	8242
Denominator			50310	50874	50874
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15.9	15.7	15.4	15.1	14.8

Notes - 2002

Data were obtained from Oklahoma PRAMS, MCH Assessment.

Notes - 2003

SPM#8: Data were obtained from Oklahoma PRAMS, MCH Assessment.

Notes - 2004

SPM#8: Data were obtained from Oklahoma PRAMS, MCH Assessment. Final data for year 2004 are not yet available. Year 2003 data are repeated.

a. Last Year's Accomplishments

This is the first year for reporting on this state performance measure that was developed and added to Oklahoma's Title V application in 2004.

Monitoring data provided by the Oklahoma State Department of Health (OSDH) Pregnancy Risk Assessment Monitoring System (PRAMS, 2003) show that 16.2% of pregnant women report smoking during the third trimester of pregnancy. These data show that 28.6% of pregnant women smoked in the three months prior to pregnancy and 24.7% continue to smoke postpartum. One in seven low birth weight births in Oklahoma is attributed to smoking during pregnancy, costing Oklahomans an excess $14.4 million per year in direct health care expenses. Among women who reported smoking during the three months before pregnancy, 44.7% quit smoking during the prenatal period. Among those who quit, 40.3% abstained from smoking for at least two to six months postpartum. Conversely, 59.7% of those who quit resumed smoking by at least two to six months postpartum.

MCH participated in discussions with the OSDH Tobacco Use Prevention Service and the Community Health Services related to implementation of alternative smoking cessation strategies with pregnant women who smoke and were being seen through county health department maternity clinics. Initiation of these strategies was delayed for the year with the Tobacco Use Prevention Service focused on activities with private physician offices.

Pregnant women seen through county health departments and contract clinics were provided with information on the impact of smoking on the health of the pregnant woman and developing fetus. Women were supported in their efforts to discontinue smoking with referral to the Tobacco Helpline 1-800-quit-now.

The Oklahoma Health Care Authority, the state Medicaid agency, began coverage of smoking cessation products for pregnant women. MCH assisted in assuring this information was shared with public and private health care providers across the state.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Explore with OSDH Community Health Services and Tobacco Use Prevention Service implementation of alternative tobacco cessation activities in county health department and contract provider maternity clinics.				X
2. Provide education about risks of smoking and connect pregnant women seen through county health departments and contract provider clinics with cessation support services.		X		
3. Assist the state Medicaid agency, Oklahoma Health Care Authority, with disseminating information about Medicaid coverage of smoking cessation products for pregnant women eligible for Medicaid.		X		
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

MCH sponsored the Oklahoma Maternity Care training in January 2005. The training included information on the effects, counseling and management of smoking during pregnancy. Resource and referral information on smoking cessation was also provided.

Information on the Oklahoma Tobacco Helpline and coverage of smoking cessation products for pregnant women having Medicaid is being shared with health care providers as MCH makes site visits. MCH has found that with staff turnover in the county health departments there are gaps in staff knowing about the availability of these services.

MCH reinitiated discussion with the Tobacco Use Prevention Service regarding alternative strategies for use with pregnant women seen through public health maternity clinics.

Responsibilities of a health educator position in MCH Women's Health Division were redefined to focus at least half of its time on preventive health activities. Tobacco use prevention will be one of the priority areas addressed. Expectations for this position are to work closely with the staff of the Tobacco Use Prevention Service and nursing staff in the Women's Health Division on education and training activities, identification and development of resources for use by providers and provision of technical assistance and consultation.

c. Plan for the Coming Year

Reducing substance abuse behaviors in the MCH populations was identified as one of the top 10 state priorities through the state needs assessment. Tobacco use prevention is a priority of the OSDH and the OSDH Board of Health. This state performance measure will be continued.

The PRAMS will continue to be a primary source of information on smoking in pregnant women. Data from the PRAMS will be used to develop a PRAMSGRAM on smoking that will include recommendations for reducing tobacco use in pregnant women. The PRAMSGRAM will be distributed to health care providers, policymakers and programs focused on tobacco use prevention. This information will also be used by MCH in planning and development of program services.

The Health Educator position in Women's Health began work on June 20, 2005. This staff is becoming acquainted with the responsibilities of this position and being integrated into activities of the Division. Plans remain in place for this staff to provide population-based services related to tobacco use prevention.

During this year, MCH will explore and identify additional activities to implement that will impact this state performance measure. Discussions will occur with the Tobacco Use Prevention Service, Community Health Services, Chronic Disease Service, contractors, Healthy Start projects and the state perinatal coalition, Healthy Mothers/Healthy Babies.

E. OTHER PROGRAM ACTIVITIES

The Oklahoma Areawide Services Information System (OASIS) continues as the statewide toll free information and referral line for MCH and the CSHCN Program (see Form 9). The telephone number for the Hotline is 1-800-OASIS. The OASIS is in operation Monday--Friday from 8:00 AM to 6:00 PM

with an answering machine for after-hours calls. Individuals who leave a message after hours are contacted the following workday; resources are not currently available to expand this service to provide 24-hour coverage. TDD/TTY services for the deaf are available and bilingual staff are available to Spanish speaking callers. The OASIS also maintains a website (http://oasis.oushc.edu) for information and referral services.

MCH continues to provide MCH Comprehensive Site Visits to county health departments and contract providers. Each health department site is on a four-year rotating schedule to receive a comprehensive visit. Technical assistance visits and a self-assessment by each site will be completed in the interim years. Contract providers will receive a comprehensive site visit every four years with routine contract monitoring visits to occur in each interim year. The MCH Comprehensive Site Visits involve a multidisciplinary team traveling to an Administrator's area or a contract provider's clinical site(s) to assess infrastructure, population-based, enabling and direct health services. A comprehensive report is prepared and forwarded to Administration of the county health department or contract agency outlining requirements and recommendations as well as timelines for addressing findings. MCH provides ongoing technical assistance in addressing areas of concern.

The CSHCN Program continues to provide site visits to all contract providers. The main focus at these visits is to discuss how their activities are tied to the six outcome measures of the CSHCN Program.

An interagency agreement was signed in April of this year outlining a collaborative relationship between the State Department of Education (SDE) and the Oklahoma State Department of Health (OSDH). This agreement provides MCH with the ability to develop policies and procedures for school health and provide technical assistance and training to school health nurses.

Infrastructure support for child care is being provided through an interagency agreement with the Oklahoma Department of Human Services (OKDHS). MCH is collaborating with the OKDHS to use Title V funds and OKDHS funds to support regional child care health consultants to provide support and technical assistance to local child care health consultants and child care facilities to assure appropriate, safe and quality care.

MCH continues to provide leadership on state policy and services to impact poor eating and physical activity behaviors. The Director of MCH Child and Adolescent Health Division co-chairs the OSDH Energy Task Force. This group focuses on nutrition strategies to improve the nutrition status of OSDH employees. MCH participates on the Task Force on the Promotion of Children's Health. This legislatively mandated task force is focused on developing action steps that can be taken legislatively to reduce childhood obesity in the state. MCH also participates in the OK Fit Kids Coalition. This coalition was instrumental this year in passage of legislation related to healthy products being placed in school vending machines and required physical education in schools.

Action for Healthy Oklahoma Kids (AHOK), a state initiative developed to mirror the national Action for Healthy Kids initiative, continues to seek to improve the health of children by creating healthier school environments. The Director of MCH Child and Adolescent Health Division co-chairs this initiative.

In addition to administering the statewide-randomized Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) in odd numbered years, MCH continues to offer, in even numbered years, the YRBS to local schools who request the survey. This provides the local school with information to use in planning for activities and programs to impact youth risk taking behaviors.

Injury prevention activities continue to be a focus for MCH. MCH provides technical assistance and state funding for the Oklahoma Poison Control Center, support for annual water safety events for elementary aged children and is involved in coordination efforts within the state utilizing the National Fire Protection Association (NFPA) Risk Watch comprehensive injury prevention curriculum.

Activities targeted toward prevention of Sudden Infant Death Syndrome (SIDS) continue to be a priority. A specific focus this year has been safe sleeping after a request was received from the State

Medical Examiner's Office to assist in intervening with these preventable deaths of infants. MCH is facilitating a work group consisting of representation from families, Children First, Healthy Families Program, SAFE KIDS Coalition, Injury Prevention Service, OKDHS and the state Child Death Review Team. This work group is exploring strategies to educate families and health care providers about safe sleeping for infants. To date, a public service announcement has been developed through use of existing OKDHS contracts and is being aired on television and radio.

In June 2005, the School Health Nurse Consultant and Child and Adolescent Health Clinical Nurse Consultant in MCH attended the Association of State and Territorial Health Organizations ((ASTHO) sponsored conference, Strengthening the Delivery of Vaccines for Adolescents, representing the OSDH. Information from this conference will be used in collaborative activities with Immunization Service, schools, colleges and universities to increase the proportion of adolescents receiving newly licensed vaccines and to identify ways to integrate these approaches with other adolescent health, education and development programs.

F. TECHNICAL ASSISTANCE

MCH has worked with the Fetal and Infant Mortality Review (FIMR) Project in Tulsa County, located at the Tulsa City County Health Department, to restructure its case review team and community action team processes. Ongoing conversations have occurred with the Oklahoma City County Health Department to establish a FIMR Project during state fiscal year (SFY) 2006. Hiring of staff for this project is to begin shortly after the beginning of the SFY. Technical assistance is requested specifically related to data issues. MCH and staff from Tulsa City County Health Department and Oklahoma City County Health Department are interested in learning how to be more efficient in data abstraction, what is too much or too little. There are no staff with data abstraction experience in MCH or employed by either of the City County Health Departments. There is also an interest in using trend data and learning if and how other states use trend data. Two states identified as able to assist with these technical assistance needs are South Carolina and Florida.

The CSHCN Program is requesting technical assistance related to transition of youth with special health care needs from a pediatric health care system to an adult health care system. Assistance is needed in developing information gathering tools and data systems that can be used in identifying gaps in services so targeted interventions can be identified for implementation. Families have expressed concern over the fact that their children's primary care and specialty providers do not give referrals to adult providers because they are hard to find, especially in the rural areas. The CSHCN Program would like to develop and maintain a resource guide for use by these youth and their families.

V. BUDGET NARRATIVE

A. EXPENDITURES

See Forms 2, 3, 4, and 5

If one looks at the overall trend from the beginning of electronic reporting in 1996 to the projected period in 2006, there is not an overall significant change in dollars available to be expended until 2002. One significant difference prior to 2002 and continuing thereafter comes to note in changing focus of grant related dollars. The other and more significant change comes from shifting of other federal programs oversight within the agency.

Within the overall federal portion of Maternal and Child Health (MCH) Block dollars committed to Maternal and Infant Health, Preventative and Primary Care for Children, and Children with Special Health Care Needs (CSHCN), there continues to be a commitment in moving more funding towards core infrastructure, population-based and enabling services, with less being appropriated towards direct health care services. Movement of these monies was initially affected in 2002 by the development of the Community Health Services' function within the Oklahoma State Department of Health's (OSDH) reorganization. The Title V MCH Chief and MCH staff have an established working relationship with this group and will continue to work closely with Community Health Services Administration in order to facilitate, as appropriate, the redirection of direct health care service dollars towards infrastructure, population-based and enabling services (see Figure 2) as needed on a county-by-county basis.

Along with movement of these resources, the OSDH continues to fine-tune its abilities to verify and report how resources are actually budgeted and spent. Both the Oklahoma Department of Human Services (OKDHS) CSHCN Part C and OSDH Community Health Services have participated in designing and implementing better methods of defining resource allocation and expenditure. Prior to the 2002 report and 2004 application, all CSHCN resources were reported as direct services because no method had been devised to allocate these resources differently. This resource allocation was revised beginning with the 2002 annual report and 2004 application to more accurately reflect true occurrence. The same is true for parts A and B, but with a lesser impact. Because of this reporting realignment, amounts in each of the categories on Table 5 vary widely from past years. It should be noted that although some resources have been reallocated to areas other than direct, much of the change this reporting period is due to reallocation methodology to better reflect the trends that have been occurring over the past several years.

B. BUDGET

Maintenance of effort from 1989:
For 1989, the OSDH administered 77.5% of the Block Grant funds, and the OKDHS administered 22.5% of the Block Grant funds. The amount of the Block Grant award for 1989 was $5,980,100. The OSDH share was $4,634,578 and the OKDHS received $1,345,522.

The agency expenditure reports indicate that a total of $4,634,578 of Block funds was expended during the grant period October 1, 1988 through September 30, 1989.

For that period, a total $4,109,415 of the OSDH and county health department resources were expended for Block Grant activities. The amount of state/local expenditures exceeded the required Block Grant match of $3,475,932 by an amount of $633,483.

The OSDH Block Grant program value is determined through the agency time and effort reporting system in which all state and local staff code their daily time to program activities. Non-personnel expenses are made as direct charges to the appropriate program budgets. State funds include state and county appropriations for local health departments. Other contributions include in-kind monies. Program income includes fee revenues from Title XIX and family planning patient fee revenues, as

applicable to the Title V Block. No other patient fee charges are made for Title V services at this time though MCH is in discussion with contract agencies that are requesting to implement fee schedules during FFY2005. The agency is audited each year by the state auditor's office following the federal guidelines applicable to the Title V Block Grant. All appropriate fiscal records are maintained to insure audit compliance.

Summary -- FY1989 Block Grant Expenditures

State Health Department of Total
Department Human Services

Title V $4,634,578 $1,345,522 $5,980,100

Match $3,475,932 $1,061,546 $4,537,478

Overmatch $146,839 0 $146,839

Income $250,000 0 $250,000

Local/Other $236,644 0 $236,644

Total $8,743,993 $2,407,068 $11,151,061

Special consideration for funding pre-1981 projects:
Prior to the Title V Block Grant, MCH funded a combined Maternal and Infant Care, Children & Youth and Dental Project in an urban area. Title V Block Grant funds continue to fund these programs although they have evolved from the "program of projects" scope. Additionally, an Adolescent Project in place prior to 1981 continues to receive a share of Block Grant funds ($89,400) originally earmarked. With the approval letter received from the Centers for Medicare and Medicaid Services (CMS) on November 5, 2004 for implementation of the Oklahoma Family Planning Waiver (April 1, 2005), MCH funding previously allocated each year for family planning services will now be realigned to support other MCH initiatives and activities focused on impacting national and state performance measures.

Special consolidated projects:
Block Grant funds will continue to be used to carry out Sudden Infant Death Syndrome (SIDS) activities and the CSHCN Supplemental Security Income-Disabled Children's Program (SSI-DCP). SIDS activities include support for SIDS education and follow-up services. The Public Health Social Work Coordinator in MCH is responsible for coordination of SIDS activities. The CSHCN SSI-DCP uses funds to provide diapers, formula, durable medical equipment, supplies, and services that would otherwise not be available to children with special health care needs.

State provides a reasonable portion of funds to deliver services:
MCH funds will continue to be targeted towards those programs for which monies may be earmarked and/or are of priority for state/local needs. Assistance will continue to be provided to state and local agencies to: 1) identify specific MCH areas of need; 2) assist in planning action or programs to address their needs; and, 3) provide resources to assist in carrying out those programs. Allocation of resources to local communities will continue to be based on such factors as: the identified need and scope of the particular health problem; community interest in developing service to eliminate the problem, including the extent and ability to which local resources are made available; ability to recruit the specialized staff which are often needed to carry out the proposed service; the cost effectiveness of the service to be provided; coordination with existing resources to insure non-duplication of services; and, periodic evaluation to determine if resources have impacted the problem. MCH will also continue support of the state Title V 1-800 toll-free information and referral system.

The OKDHS administers the CSHCN Program through the Family Support Services Division (FSSD),

Health Related and Medical Services Section. The FSSD is administratively responsible for the CSHCN Program and also administers the SSI-DCP, one of the components of the CSHCN Program, for SSI recipients to age 18. Other components of the CSHCN Program include two projects that support neonates and their families; support of the state Title V 1-800 toll-free information and referral system; sickle cell services; respite care services for medically fragile children; medical, psychological, and psychiatric services to the CSHCN population in the custody of the OKDHS; funding for travel, training, and child care for parents of children with special health care needs; and, a project that is establishing an integrated community-based system of services for children with special health care needs in several communities in the state. Coordination will continue between the FSSD and the Oklahoma Health Care Authority (OHCA) to ensure services are not duplicated and policies and procedures are in compliance with federal and state mandates. The FSSD will continue to utilize Title V funding to assure the development of community-based systems of services for children with special health care needs and their families.

Anticipated federal MCH dollars, state matching funds:
Based on a FFY 2006 preliminary Title V Block Grant allocation of $7,743,394, a minimum of 30% ($2,323,019) must be designated for programs for prevention and primary care services for children and 30% for services for children with special health care needs. It is understood that the combined components must also meet the required match of three state dollars for each four federal dollars. These requirements will be met with estimated budgets reflecting the following as estimated validated program costs:

Budget Title V Cost Sharing Total

Prevention and
Primary Care
for Children $2,936,797 $3,584,585 $6,521,382
(37.93%)
Children with Special
Health Care Needs $2,323,019 $1,742,263 $4,065,282
(30.0%)

Maternal & Infant Care $1,709,239 $3,170,277 $4,879,516
(22.07%)

Administration $ 774,339 (10.0%) $566,316 $1,340,655

Total $7,743,394 $9,063,441 $16,806,835

Other federal programs or state funds to meet needs and objectives:
The State Systems Development Initiative (SSDI), a grant funded by the Maternal and Child Health Bureau (MCHB), will continue activities to link WIC data with birth certificates and Medicaid eligibility and claims data. This is a continuation of Oklahoma's goal to link relevant program services to existing MCH databases including the Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) surveillance systems. These linkages will enable the state to generalize the results to Oklahoma's population of pregnant mothers and young children.

The Healthy Child Care Oklahoma Project, a grant funded by the MCHB, ended January 31, 2005. Activities from this grant have been transitioned into the state plan for early childhood. MCH submitted a proposal to MCHB on May 27, 2005 for implementation funding for FFY 2006 as part of the MCHB funded Early Comprehensive Childhood Systems (ECCS) PlanningGrant.

The PRAMS, funded primarily by the Centers for Disease Control and Prevention (CDC) with additional support provided by Title V, will continue to provide population-based data on maternal and infant health issues. This information will be used to educate health care providers on maternal and infant health issues, recommend health care interventions, monitor health outcomes, and provide

support for policy changes.

Title X federal funding will continue to provide family planning services through county health departments and contract clinic sites. Title X funds will be used to provide a variety of educational programs targeted at decreasing unintended pregnancies, postponing sexual activity in teens, prevention of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV), and increasing knowledge of human sexuality.

The Oklahoma State Department of Education will continue to provide federal funds received from the CDC to the OSDH through a contractual agreement. MCH will use these funds to support ongoing administration of the Youth Risk Behavior Survey. This survey provides Oklahoma with information on risk taking behaviors of youth.

State perinatal monies will continue to be utilized by MCH to provide services for pregnant women and infants.

Budget Documentation:
Overall budget preparation and monitoring will be provided through administrative support within the OSDH Administrative Services. Budget and contract staff will continue to meet regularly with program areas to assure program financial awareness. The MCH Service Chief will be responsible for budget oversight and the Chief along with each individual Division Director will be responsible for compliance with program standards and federal and state requirements.

The OSDH receives an annual independent audit of program and financial activities. The State's Office of the State Auditor and Inspector conducts this annual statewide single audit. Additionally, the agency maintains an internal audit staff that reviews county health departments and subcontractors for compliance with contract fiscal matters relating to OSDH support. This staff reports directly to the Commissioner of Health.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.